CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

RP 21007

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED D'RING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE: Certificate of Death

2. Form No. if available:

3. Type—(cards, paper, etc.): Bound Book

4. Dates:

5. Volume accumulated yearly:

6. Size of Record: Misc.

7. Number of copies made: One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period

a. In Dept.: 12 yrs.

b. In Storage Center: Micro. Perm.

c. Total: 12 yrs. and Micro. Perm.

10. Equipment and space freed:

11. In your opinion does this record have any historical significance?

YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval: Robert E. Farber M.D. Title: Commissioner of Health Date: 3/28/63

Recommendation of Records Management Officer

13. Recommended Retention Period

a. In Dept.: 12 yrs.

b. In Storage Center: Microfilm Permanent

c. Total: 12 yrs. and Microfilm Permanent

14. Disposal Method

A. [ ] To be sold as scrap or waste paper

B. [X] To be Burned or shredded

C. [ ] Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS: 2 negative Rolls

C P Force — Records Management Officer — Date: 3/28/63

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

EP 23907

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—1-30—M. & T.—250 Bks.

E 56476 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56476

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 21-29 ST., WARD)

2-FULL NAME Annie W. Lewis

(a) RESIDENCE NO. 902 Burgundy ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 6 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Unknown Lewis

6 DATE OF BIRTH (month, day, and year) ~~Unknown~~ 10/7/1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78 ~~86~~ ?	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER ~~Unknown~~ Henry C. Muller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ~~Unknown~~ Dorothy Kackbeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Records of Balto. City Hosp.

15 Filed APR 24 1930 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-23-30

17 I HEREBY CERTIFY, That I attended deceased from 4-21-21, 19..., to 4-23-30, 19...,

that I last saw her alive on 4-23-30, 19...,

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Diffuse

(duration) 9? yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis: Senile Dementia

(duration) over 3 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home & Care

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McClean, M. D.

4-24, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Apr 26 1930

20 UNDERTAKER H. J. Tinker, Jones

ADDRESS [illegible]

Spec.—1-12-23—M&T—500 Blks.

E 56477

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56477

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2410 Brohawn Av (ST.) 75-73 (WARD)

2-FULL NAME Ethel Isaac

(a) RESIDENCE NO. 2410 Brohawn Av (ST.) ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Milton L. Frank

6 DATE OF BIRTH (month, day, and year): July 8 1906

7 AGE — Years: 23 — Months: 9 — Days: 16 — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: George A. Fold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Josephine Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Milton L. Frank 2410 Brohawn Av. Lakeland

15 Filed ..... 19 ..... Registrar

APR 24 1930

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/24/1930

17 I HEREBY CERTIFY, That I attended deceased from 4/10/1930, to 4/23/1930,

that I last saw h[illegible] alive on 4/23/1930,

and that death occurred, on the date stated above, at 2300 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) Influenza (duration) ..... yrs. ..... mos 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Reginald Doan, M. D.

19 ..... (Address) 4209 Roslyn Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: April 26 1930

20 UNDERTAKER: E. Schlosman & Son — ADDRESS: 1039 Hanover St

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56478

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56478

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 20-24 WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Alfred Hockstein

(a) RESIDENCE NO. 2019 W. Baltimore st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Hockstein

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
34	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe fitter 6-4

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 6-5

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Hockstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Grose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records (Address)

15 Filed 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 15, 19 30 to April 23, 19 30, that I last saw him alive on April 23, 19 30, and that death occurred, on the date stated above, at 12.01 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinica.

(Signed) Jas. Garner M.D.

4-23 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL apr 28 1930

UNDERTAKER Vernon Kechner

ADDRESS 1432 Hollins

FROM A very important

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 E 56479

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 56479

1-PLACE OF DEATH

City of BALTIMORE: (No. 1811 W. Lafayette Ave. 16-22 Ward)

2-FULL NAME Mona (Baby Cooley)

(a) RESIDENCE NO. 1811 W Lafayette Av St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 21 / 1930

7 AGE	Years	Months	Days	IF LESS than 1 day / X hrs. or ____ min.
	—	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) 1811 W Lafayette Av
(State or country)

PARENTS

10 NAME OF FATHER Wister F. Cooley

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary F. Sullivan

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Virginia

14 Informant Father
(Address)

15 Filed _____ 19 _____ Registrar

APR 24 1930 C. HAWSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 21 1930 to Apr 21 1930, 4 P.M.
3 40 A.M.
that I last saw her alive on Apr 21 1930,
and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:
6 month fetus

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY _____
(Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted —
If not at place of death? —
Did an operation precede death? No Date of _____
Was there an autopsy? no
What test confirmed diagnosis? Gross
(Signed) H. R. Mercer, M. D.
4/21, 1930 (Address) 3921 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Reclined to John Hopkins

Date of Burial 4/21 1930

ADDRESS

20 UNDERTAKER
Embry Surgical Laboratory

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M[illegible]—250 Bks.

E 56480 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56480

31

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 909 Carnegie ave ST., 26-3T WARD)

2-FULL NAME George Baier

(a) RESIDENCE NO. 909 Carnegie ave ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Baier

6 DATE OF BIRTH (month, day, and year) Jan 24-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) in Boiler Shop

(c) Name of employer Bethlem Steel Co

9 BIRTHPLACE (city or town) (State or country) Bad G. Prd. Germany

PARENTS

10 NAME OF FATHER John Baier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosinda Weiler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ella Baier Wife
(Address) 909 Carnegie ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to April 22, 1930, that I last saw h— alive on April 22, 1930, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 1 yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Francis B. Tuttle, M. D.

4/23, 1930 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrid Hearts Cem

DATE OF BURIAL April 26 30

20 UNDERTAKER Lellya Zeiler MC

ADDRESS 403 S Clo[illegible]

TION is very important. See instructions on reverse side.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56481

3 1 E 56481

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1900 Baile ST., 2-4 WARD)

2-FULL NAME Wilhelm Fredrich

(a) RESIDENCE NO. 1900 Baile ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Fredrich

6 DATE OF BIRTH (month, day, and year) Jan 16 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Katherine Fredrich

(Address) 1900 Baile St.

15 Filed APR 24 1930 19 Registrar L

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22/30

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1930, to April 22, 1930, that I last saw him alive on April 22, 1930, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

1 Lobar Pneumonia

(duration) 1 yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chas. Heller, M. D.

4.23. 1930 (Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery DATE OF BURIAL April 25 1930

20 UNDERTAKER Lilly&ZeilerInc. ADDRESS 403 S.Wolfe

FRONT (Very important—See instructions)

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-002 ✓

E 56482

CERTIFICATE OF DEATH

E 56482

REGISTERED NO. E 56482

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Sinai Hospital St., 7-13 Ward)

2-FULL NAME Jacob H. Miller

(a) RESIDENCE NO. 1033 Rutland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Eva M Miller

6 DATE OF BIRTH (month, day, and year) Nov 14/1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57	5	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Proprietor
(b) General nature of industry, business, or establishment in which employed (or employer) Public Garage
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Switzerland

PARENTS

10 NAME OF FATHER Henry Miller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Switzerland

12 MAIDEN NAME OF MOTHER Susanna Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Switzerland

14 Informant Eva M. Miller
(Address) 1033 Rutland Ave

15 Filed APR 24 1930 19 H. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage (Eroded area)

Splenic Anemia (Banti's?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Sinai

What test confirmed diagnosis?

(Signed) J. H. Waters, M. D.

5/24/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 26, 30
20 UNDERTAKER	ADDRESS
George W. Zirkler	1737 E. Eager St.

IMPORTANT: Physician, Undertaker, Coroner, Agent, etc., are required to comply with the law governing the registration of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 56483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56483

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4-30 Ward)

2-FULL NAME Jessie A. Vanegraft

(a) RESIDENCE NO. Grafton, W. Va St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lora Vanegraft

6 DATE OF BIRTH (month, day, and year) June 7-1887

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	42	10	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bridge carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) B & O. R. R. Co.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) W. Va

PARENTS

10 NAME OF FATHER Michael Vanegraft

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Margaret E. Moody

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Samuel L. Boyce
(Address) Grafton W. Va.

15 Filed ... 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Spine, Accidental Death. Struck by Falling Timber (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Astor Branch W. Va

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Eugene Fellers, M. D.

4/24, 1930 (Address) 2734 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Barton's Grafton W Va — DATE OF BURIAL 4-24 1930

20 UNDERTAKER Robert Brooks & Son — ADDRESS Grafton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 24 1930 PARSON JOHNS, M. D.

Spec.—1-30—M. & T.—250 Blks

E 56484 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56484

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Poplard ST. 25-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith M. Kasemeyer

(a) RESIDENCE NO. 1504 Poplard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 31. 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	23 yr	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frederick Kasemeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Margaret M. Ackman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Frederick Kasemeyer.

(Address) 1504 Poplard St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23/30.

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1930. to April 23. 1930

that I last saw h.E alive on April 23. 1930

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Uremic Colitis

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. Campbell M. D.

4/24 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Apr 25. 1930.

20 UNDERTAKER Wm. Mus. J. M. Teufel & Son

ADDRESS 501 W. Fayette

TION is very important. See instructions on back of Certificate.

R 2 [illegible] HAMILTON JOHNS, M. D.

Spec.—1-10-21—M&T—1500 Bks.

E 56485

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56485

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen'l Hospital WARD)

2-FULL NAME Baby Female DeVries

(a) RESIDENCE NO. Baltimore, Md. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe

4 COLOR OR RACE: Cauc.

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — If LESS than 1 day, ... hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John C. DeVries

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Maryland

12 MAIDEN NAME OF MOTHER Emma Kibler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co. Md.

14 Informant Hospital Records
(Address)

15 Filed APR 24 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1930

17 I HEREBY CERTIFY, That I attended deceased from April 22. 1930. to April 22. 1930.
that I last saw h[illegible] alive on April 22. 1930.
and that death occurred, on the date stated above, at 5[illegible] A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible], M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hoken

DATE OF BURIAL: 19

20 UNDERTAKER .....

ADDRESS .....

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of SOCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 56486

HEALTH DEPARTMENT—CITY OF BALTIMORE

148 F 56486

CERTIFICATE OF DEATH.

REGISTERED NO. 13-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto General Hosp ST. 13-52 WARD

2-FULL NAME Mrs. Dorothy F. Smith

(a) RESIDENCE NO. 831 W. 35 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jean G. Smith

6 DATE OF BIRTH (month, day, and year) Jan. 20-1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	23	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James B. Hessong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Edith Irwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant James B. Hessong (Address) 809 E. 36th St.

15 Filed APR 24 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/21, 1930, to 4/22, 1930, that I last saw her alive on 4/22, 1930 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Clinical & laboratory

(Signed) L. H. Klemm, M. D.

19 (Address) West Balto Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL April 25 1930

20 UNDERTAKER Horace F. Burgee — ADDRESS 3631 Falls Road

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates.
TION is very important

1-30—M. & T.—100 B—50L

E 56487

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 56487

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1171 N. Green ST., 4-25 WARD)

2-FULL NAME Andy Gumps - Alias Bellon

(a) RESIDENCE NO 117 N. Green ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... ~
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER ~

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER ~

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....
(Address)

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) april 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Eugene Zeller, M. D. Coroner

4/22, 1930 (Address) 1739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
UNIVERSITY OF MARYLAN

DATE OF BURIAL APR 24 1930 19

20 UNDERTAKER

ADDRESS

C. HAMPSON JONES, M.D.
Commissioner of Health.
For Wm. F. Cogill

APR 24 1930
THE MORGUE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Page ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56488

E 56488

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hosp. 10 12
CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME George F. Kothe

(a) RESIDENCE NO. 2234 Eagle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/22/1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	11	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tel. operator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Gustave Kothe
11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)
12 MAIDEN NAME OF MOTHER Amelia Schalkenberger
13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Hospital record
(Address)

15 Filed APR 24 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/25, 1930, to 4/23, 1930,
that I last saw him alive on 4/23, 1930,
and that death occurred, on the date stated above, at 9 35 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia (duration) yrs. ... mos. 3 wks

CONTRIBUTORY (Secondary) Abscess of buttocks & hemorrhage (duration) .. yrs. mos. 3 wks

18 Where was disease contracted if not at place of death? home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) ..... M. D.
19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore
DATE OF BURIAL April 26 1930

20 UNDERTAKER Thanhauser
ADDRESS 3615 E. T

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CONDITION is very important. See instructions on back of certificates.

R 24 1930

C. HARRISON JONES, M. D.

Spec.—2-29-28—L. F. 3.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56489 44 E 56489

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3209 Belvedere Ave ST. 27-36 WARD)

2—FULL NAME Edwin W. Gorsuch

(a) RESIDENCE NO. 3209 Belvedere Ave ST. WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Callie E Gorsuch

6 DATE OF BIRTH (month, day, and year) Aug 8 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co

PARENTS

10 NAME OF FATHER Thomas Gorsuch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co

12 MAIDEN NAME OF MOTHER Matilda Bantham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co

14 Informant Callie E. Gorsuch

(Address) 3209 Belvedere Ave

15 Filed Apr 24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 30

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Apr 23, 1930, that I last saw h[illegible] alive on Apr 23, 1930 and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Face Forehead

(duration) 5 yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of Jan 1930

Was there an autopsy? —

What test confirmed diagnosis? Operation

(Signed) Charles E Peck, M. D.

19 (Address) 5276 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Pleasant Carroll Co DATE OF BURIAL April 26, 1930

20 UNDERTAKER Ehrenwall Son ADDRESS 3615 Chestnut Ave

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56490

CERTIFICATE OF DEATH

46 E 56490

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 Mount ave ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Annie T. Smith

(a) RESIDENCE NO. 2206 W. North ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 7 mos. 22 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Wht	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept 2nd 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) London
(State or country) Eng.

12 MAIDEN NAME OF MOTHER Josephine V. Silvard

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mr Helen Shafer

(Address) 3804 Chatsworth Rd.

15 Filed G. HAMPSON JONES, M. D. Registrar

APR 24 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 24/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 1927, to Apr. 24, 1930, that I last saw h[illegible] alive on Apr. 24, 1930 and that death occurred, on the date stated above, at 12 00 p. m.

The CAUSE OF DEATH* was as follows:

Recurrent Carcinoma beginning in Ulcus Mobile stomach by Wm B. Parry Oct 1927

(duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Nothing & probably Carcinoma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 27

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Eastwick M. D.

4/25/1930 (Address) 1605 Mount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loraine — DATE OF BURIAL Apr 26 1930

20 UNDERTAKER G. Geo W Little — ADDRESS 2700 Edmondson Ave

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 56491

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 56491

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2524 Eastern Ave St. Ward)

2-FULL NAME Bernard Scott

(a) RESIDENCE NO. 2524 Eastern Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helena

6 DATE OF BIRTH (month, day and year) 12-14-91

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38	5	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Warburton

9 BIRTHPLACE (city or town) Washington
(State or country) D.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Edward F. Scott
(Address) 2524 Eastern Ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 24th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry,) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. Sudden

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leavitt, M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	4/26 1930
20 UNDERTAKER Henry W. Myers & Son	ADDRESS 805 W. Lexington

tion should be carefully supplied. Avoid abbreviations. Write plainly with pen and ink. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

4 24 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 56492

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56492

CERTIFICATE OF DEATH

65

REGISTERED NO. 26-42

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilbert Schaaf

(a) RESIDENCE NO. 4412 Bayonne ave. ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 8 mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11.	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Henry Schaaf

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Thies

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Henry Schaaf
(Address) 4412 Bayonne Ave

15 Filed ....., 19 .....

C. HAMPTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/28/30.

17 I HEREBY CERTIFY, That I attended deceased from 4/8, 1930, to 4/23, 1930, that I last saw h im alive on 4/23, 1930, and that death occurred, on the date stated above, at 1.20 p.m.

The CAUSE OF DEATH* was as follows:

Acute Lymphoid Leukemia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no. Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clin & Path

(Signed) Henry D. Councill, M. D.

19 (Address) Univ Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Loudon Pk Cem.	April 26 1930

20 UNDERTAKER A. Howard Evans ADDRESS 38 E Fort ave

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56493 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56493

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 E. Fort Ave. ST 24-33 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F. Tiviny.

(a) RESIDENCE NO. 428 E. Fort Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Tiviny.

6 DATE OF BIRTH (month, day, and year) About 1854.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. do

(b) General nature of industry, business, or establishment in which employed (or employer) Factory Employe

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Dont know.

11 BIRTHPLACE OF FATHER (city or town) Dont know. (State or country)

12 MAIDEN NAME OF MOTHER Mary L. Millen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Sig.) J. Tiviny (Address) 428 E. Fort Ave.

15 Filed APR 24 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to April 23, 1930, that I last saw h-im alive on April 23, 1930, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Arteria sclerosis with Hypertension

(duration) ? yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) ? yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Streett, M. D.

4/24 1930 (Address) 448 E Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk Cem	April 26 1930
UNDERTAKER C. Howard Evans	ADDRESS 358 E Fort Ave

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56494 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56494

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 5-8 ST., WARD)

2-FULL NAME Theodore Stunz

(a) RESIDENCE NO. 335 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27, 1873?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56?	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John S. Stunz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Johanna Wenkert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed R 24 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24-30

17 I HEREBY CERTIFY, That I attended deceased from 3-4-30, 19, to 4-24-30, 19, that I last saw him alive on 4-24-30, 19, and that death occurred, on the date stated above, at 8:10 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) 1? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin W. McLean, M. D.

4-24, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 4/26/1930

20 UNDERTAKER Wm Cook 1217

ADDRESS St Paul

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

Paul Byerly 3648 W Lafayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 56105

91-002

B 56105

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2916 Clifton Ave St., 15-6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nancy L Smith

(a) RESIDENCE NO. 2916 Clifton Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William O Smith

6 DATE OF BIRTH (month, day, and year) Feb 25, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Littleton Harmon

11 BIRTHPLACE OF FATHER (city or town) Ga
(State or country)

12 MAIDEN NAME OF MOTHER Charlotte Stevens

13 BIRTHPLACE OF MOTHER (city or town) Cambridge Md
(State or country)

14 Informant Mrs Nancy Snyder
(Address) 2916 Clifton Ave

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1 1930 to Apr. 23 1930,

that I last saw her alive on Apr 23 1930

and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility - Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm P Byerly M. D.

4/24/30 (Address) 3648 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 4/25 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

important. See instructions on back of certificates.

HARRISON JONES M D

Spec.—J-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56496

CERTIFICATE OF DEATH.

44 E 56496

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 South Hare St. ST. 1-2 WARD)

2-FULL NAME Sophia LeCompte

(a) RESIDENCE NO. 14 South Hare St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of or) WIFE of Humphrey Loups

6 DATE OF BIRTH (month, day and year) Jan

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or.....min.
	68	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis LeCompte (Address) 14 S. Hare St.

15 Filed APR 24 1930 HAMPSON JONES, M. D. Registrar

By RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1929 to April 23, 1930, that I last saw her alive on April 23, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. A. Cumberland, M. D.

4/24 1930 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL 4-25-1930

20 UNDERTAKER Geo. Colton Co. ADDRESS 124 St. Paul St.

CAUSE OF DEATH MUST BE FILLED IN. See instructions on back of certificates.

Spec.—19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56497

CERTIFICATE OF DEATH.

90 E 56497

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2901 Penman St. 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Halloran.

(Residence in Baltimore: No. 2901 Penman St.; 60 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, March (Month) 18th (Day), 1854 (Year)

7-AGE, 76 yrs. 1 mos. 4 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Michael Halloran

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Margaret Kane

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. A. Fraser

(Address) 2901 Penman

APR 25 1930

15-DATE RECEIVED ..... 19..... HAMPSON JONES, M. D. Registrar.

Per .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 22 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 16 1930, to April 22 1930, that I saw him alive on April 22 1930, and that death occurred, on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Wrath

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) A. D. Driscoll M. D.

4/22/30 (Address) 1211 Mulberry St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Helena — DATE OF BURIAL. 4/25 1930

20-UNDERTAKER H. Brannigan & Son — ADDRESS 1136 Poplar Grove St

CAUSE OF DEATH must be plainly written. All items important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56498 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56498

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Ella J. Stafford

(a) RESIDENCE NO. 103 Beechwood Ave Catonsville Md. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: W | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Frank J. Stafford

6 DATE OF BIRTH (month, day, and year) 2/12/1878

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER John Bosley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER McKeown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant Frank J. Stafford

(Address) 103 Beechwood Ave Catonsville Md.

15 Filed APR 25 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23/30

17 I HEREBY CERTIFY, That I attended deceased from 2/13, 1930, to 4/23, 1930, that I last saw h alive on 4/22, 1930 and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Leo. E. Stacy Jr., M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 4/26/30

20 UNDERTAKER: H. Bowman Sons — ADDRESS: 1136 Park Ave

OF DEATH in plain terms, so that important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56499

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 56499

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 N. Parish ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Louden

(a) RESIDENCE NO. 404 N. Parish ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Louden

6 DATE OF BIRTH (month, day, and year) Nov 20-1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Harris Byrd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alice Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lucy Johnson

(Address) 1400 Mosher

15 Filed APR 25 1930 16 HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23 - 30

17 I HEREBY CERTIFY, That I attended deceased from Mar 24, 1930, to Apr 23, 1930, that I last saw h alive on Apr 22, 1930 and that death occurred, on the date stated above, at 5.55 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Negative

What test confirmed diagnosis?

(Signed) H. Lynch, M. D.

Apr 24 (Address) 1401 N Mt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr 25 1930
20 UNDERTAKER Sam'l M. Chase Son	ADDRESS 1400 Mosher

Important. See instructions on back of certificates.

A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56500

E 56500

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 626 N. Vincent St. 16-27 Ward)

2-FULL NAME Leroy Wm Eshpeuil

(a) RESIDENCE NO. 626 N. Vincent St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): Dec 2 1929

7 AGE: Years | Months: 2 | Days: 22 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER: Robt Eshpeuil

11 BIRTHPLACE OF FATHER (city or town): Virginia
(State or country)

12 MAIDEN NAME OF MOTHER: Susie Whitaker

13 BIRTHPLACE OF MOTHER (city or town): Balto
(State or country) Md

14 Informant: Susie Eshpeuil
(Address) 626 N. Vincent

15 Filed ....., 19.... HAMPSON JONES, M. D. Registrar

APR 25 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, aforesaid find that said deceased came to death (autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. Hampson Jones, M. D. Coroner

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary April 26 1930

DATE OF BURIAL

20 UNDERTAKER: Joseph A Leby 409 N Mount St

ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—1-12-33—M&T—500 Blks.

E 56501

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 E 56501

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 239 N. Stricker ST. 14-7 WARD)

2-FULL NAME Wm. H. Banks.

(a) RESIDENCE NO. 239 N. Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Banks

6 DATE OF BIRTH (month, day, and year) July 20 1894

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
35 36	8 9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Thomas Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Carline Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Matilda Banks (Address) 239 N Stricker St

15 Filed APR 25 1930 C. HAMPTON [illegible], M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 24, 1930, to Apr. 22, 1930, that I last saw him alive on Apr. 22, 1930, and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

acute Pneumonia Influenza.

(Followed exposure to cold)

(duration) yrs. mos 30 ds.

CONTRIBUTORY —

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C. N. Pigott, M. D.

4/24 1930 (Address) 1536 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
U. S. National	April 25 1930
20 UNDERTAKER	ADDRESS
Joseph A Lively	409 N Mount St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Bpsc.—8-16-29—L. P. S.—100 Blks.

E 56502

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56502

101-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Provident Hospital ST. 15-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Johnson

(a) RESIDENCE NO. 1322 Caltharn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) D. C
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Annie Prettyman (Friend)

(Address) 1322 Caltharn St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-23-30

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1930, to April 23, 1930

that I last saw h alive on April 23, 1930

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M Steen, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn April 25	1930
20 UNDERTAKER	ADDRESS
Joseph A Swirly & Son	Mount St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56503

CERTIFICATE OF DEATH

56503

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Rear 1329 N. Gilmor St., 15-21 Ward)

2-FULL NAME Thos Jr. Woods Jr.

(a) RESIDENCE NO. 1428 N. Carrollst., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): Jan 3rd 1921

7 AGE: Years 9 | Months 2 | Days 28 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md

PARENTS

10 NAME OF FATHER: Thos Woods

11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)

12 MAIDEN NAME OF MOTHER: Nellie Owens

13 BIRTHPLACE OF MOTHER (city or town): Md.
(State or country)

14 Informant: Nellie Woods
(Address): 1428 Carroll

Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidently - Building collapsed fell on boy
Fractured Skull
(duration) Instantly

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Rear 1329 N. Gilmor

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. C. Jack, M. D.

(Address) 1329 N. Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: 4/25 1930

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1302 Eastman

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 25 1930 C. HAMPSON JONES

For

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56504

CERTIFICATE OF DEATH

E 56504

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No.) City Hospital St. 18-26 Ward)

2-FULL NAME Hattie Carter

(a) RESIDENCE NO. 918 Vine St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frederick Carter

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town)
(State or country) new York city

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) —

12 MAIDEN NAME OF MOTHER Lula Carter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Frederick Carter
(Address) [redacted] Vine St

15 Filed C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to not death on the day stated above.
The CAUSE OF DEATH* was as follows:
Alcoholism
Cerebral Haemorrhage

(Duration) yrs. about 14 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? By History
(Signed) A. C. Eades, M. D.
, 19 (Address) 1430 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery
DATE OF BURIAL 4/25, 1930

20 UNDERTAKER Thomas E. Kelam.
ADDRESS 1303 Pennsylvania Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56505

HEALTH DEPARTMENT—CITY OF BALTIMORE

29 E 56505

CERTIFICATE OF DEATH

REGISTERED NO. 46-67

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2906 Belmont Ave (1ST) WARD)

2—FULL NAME Daniel B Buckley

(a) RESIDENCE NO. 2906 Belmont Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	10	28 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Daniel Buckley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Heaphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Dorothy Kenwalde

(Address) 2906 Belmont Ave

15 Filed 4-28, 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from March 27th 1930, to April 23rd 1930,

that I last saw him alive on April 23rd 1930

and that death occurred, on the date stated above, at 11 05 A.M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) 3 yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchitis

Senility & Hemiplegia (duration) 11 yrs. 6 mos. da.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) D. Edgar Ray, M. D.

(Address) 2919 Belmont ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Apr 26 1930

ADDRESS 901 Fallsway

20 UNDERTAKER John J Cowan & Son

OF DEATH in plain terms, so that it may be properly classified. [illegible] statement of occupation is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56506

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 56506

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 W. West St. WARD) 23-31

2—FULL NAME John H. Bransby

(a) RESIDENCE NO. 19 W. West St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Bransby

6 DATE OF BIRTH (month, day, and year) Apr. 5. 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer) Self.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Chas. Bransby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Susan Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs Emma Bransby

(Address) 19 W. West St

15 Filed ..... 19 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from May 3rd 1924 to April 23rd 1930

that I last saw h— alive on April 22nd 1930

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation of Heart

(duration) 5 yrs. 11 mos. 20 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) Unmediate.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Harry Kleibel, M. D.

1930 (Address) 1224-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL April 25 1930

20 UNDERTAKER Fred A. Klausmeier

ADDRESS 703 Hanover

IMPORTANT—Fill in plain terms, so that it may be properly classified. Every statement of occupation is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56507

CERTIFICATE OF DEATH.

90 E 56507

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 753 N Franklin St. 17-16 (WARD)

2-FULL NAME Mary E. Stanley

(a) RESIDENCE NO. 753 N Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ or) WIFE of George Stanley

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1884

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) West River Md
(State or country)

PARENTS

10 NAME OF FATHER Richard Burgess

11 BIRTHPLACE OF FATHER (city or town) W. River Md
(State or country)

12 MAIDEN NAME OF MOTHER Jane Bowie

13 BIRTHPLACE OF MOTHER (city or town) W. River Md
(State or country)

14 Informant Viola Young
(Address) 753 N Franklin

15 Filed APR 25 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 8, 1930. to April 23, 1930.

that I last saw her alive on April 20, 1930.

and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Valvulitis

(duration) Unknown ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Dr. F. Howell Jr. M.D.

4/24 1930 (Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL April 26, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 3224 Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56508 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56508

CERTIFICATE OF DEATH.

74-02

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST., 15-58 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr David Black

(a) RESIDENCE NO. 4328 Pk Heights ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-10-1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	6	14	
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motion picture Operator

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Morris Black

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Levine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jake Black (Address) 911 S. Eutaw St

15 Filed ... 19... Registrar

C. HARRISON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24-30

17 I HEREBY CERTIFY, That I attended deceased from 4-21, 1930, to 4-24, 1930, that I last saw him alive on 4-24, 1930, and that death occurred, on the date stated above, at 3:40 A m.

The CAUSE OF DEATH* was as follows:

Sinus Cavernous Thrombosis bilateral

Septicemia - Organism (?)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cellulitis of Nose

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? Yes

What test confirmed diagnosis? Demand of Autopsy

(Signed) M. D.

4/25, 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Weber Mausoleum DATE OF BURIAL 4/25 1930

UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF ... TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

(Jackson)

E 56509

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56509

CERTIFICATE OF DEATH

× 31

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Provident Hospital 4th-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ahamed Mensen (Ahmed Mensen)

(a) RESIDENCE NO. From S.S. Envoy S.S. Essex Envoy ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Arab	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman or Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) ok

(c) Name of employer on S. S. Essex Envoy

9 BIRTHPLACE (city or town) Arabia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Dr. Sindler Ve. 4109

(Address) 2348 Eutaw Place

15 Filed APR 25 1930 C. HAMPSON JONES, Registrar

By KRK.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24-30

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1930, to April 24, 1930, that I last saw h~~im~~ alive on April 24, 1930 and that death occurred, on the date stated above, at 8 15 ~~p~~ m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical - Laboratory

(Signed) Carroll W. St Clair, M. D.

4/24, 1930 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Apr. 25 1930

20 UNDERTAKER Herbert Cook

ADDRESS 1003 West Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56510

CERTIFICATE OF DEATH.

129 E 56510

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto General Hosp. 700-10 WARD)

2-FULL NAME Mrs Alice Virginia Vivian

(a) RESIDENCE No. 127 Monastery Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albertus Vivian

6 DATE OF BIRTH (month, day, and year) Sept. 22, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Columbus (State or country) Ohio

PARENTS

10 NAME OF FATHER John Hambleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary V. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mr. Brandt L. Windle

(Address) 127 Monastery Ave.

15 Filed APR 25 1930 16 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/14, 1930, to 4/24, 1930,

that I last saw her alive on 4/24, 1930,

and that death occurred, on the date stated above, at 11:40 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) S. A. Alessi, M. D.

4/24 1930 (Address) West Balto General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Apr. 28, 1930

20 UNDERTAKER Joseph D. Cook

ADDRESS 1003 West Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56511

E 56511

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 14-20 ST.) (WARD)

2-FULL NAME Alfreda Christine Light

(a) RESIDENCE No. 1608 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER Ellsworth Light

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Rose Belle Hearne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indiana

14 Informant Hospital Record (Address)

15 Filed ..... 19 ..... Registrar

C. HARRISON JONES, M. D.

APR 25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24-30

17

I HEREBY CERTIFY, That I attended deceased from 4-17, 1930, to 4-24, 1930,

that I last saw her alive on 4-24, 1930,

and that death occurred, on the date stated above, at 3 40 P. m.

The CAUSE OF DEATH* was as follows:

Salpingitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of 4/19/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical & operative

(Signed) J. Leyko M. D.

4/24, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Apr. 26 1930

20 UNDERTAKER Street & Cook

ADDRESS 1003 West Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT NATURE OF DISEASE. TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56512 45 E 56512

CERTIFICATE OF DEATH

REGISTERED NO. 5561

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3306 Forest Park Ave. WARD)

2—FULL NAME Leon Hoffman

(a) RESIDENCE NO. 3306 Forest Park Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia S. Hoffman

6 DATE OF BIRTH (month, day, and year) Nov. 14, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York, N. Y.

PARENTS

10 NAME OF FATHER Simon Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. S. S. Hoffman (Address) 3306 Forest Park Ave

APR 25 1930 Filed HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24th, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1928, to April 24th, 1930, that I last saw h[illegible] alive on April 23rd, 1930 and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of rectum

(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Hamburg, M. D.

19 (Address) 3735 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jeshuron Cem. Philadelphia, Pa.

DATE OF BURIAL 4/27/1930

20 UNDERTAKER David Sandstein

ADDRESS 118-20 W. Mt. Royal Ave

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 E 56513

E 56513

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 Mosher ST., 14-20 WARD)

2-FULL NAME Elizabeth Thomas.

(a) RESIDENCE NO. 633 Mosher ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Thomas

6 DATE OF BIRTH (month, day, and year) March 13 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Robert Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ousus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Owens
(Address) 633 Mosher St.

15 Filed APR 25 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23, 30

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1929 to Apr 23, 1930,
that I last saw h alive on Apr 23, 1930
and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) L. C. Glenn, M. D.
19 (Address) 2329 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Apr 25 1930

20 UNDERTAKER Franklin W Sahl — ADDRESS 709 W 33rd St

TION is very important. See instructions on back of certificates.

E 56514 ✓

Spec.—8-16-29—L. F. S.—100 Bks.

E 56514 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 44

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST., 1-1 WARD)

2—FULL NAME Joshua Miller

(a) RESIDENCE NO. 705 S. Hukins Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	wid-

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia L. Miller

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 3rd

(b) General nature of industry, business, or establishment in which employed (or employer) Balt City

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Joshua Miller

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Theresa Cross

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Hosp. Records (Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24-30

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1930, to April 24, 1930, that I last saw h/ M. alive on April 24, 1930 and that death occurred, on the date stated above, at 4:25 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. ..... mos. 17 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of March 21-1930

Was there an autopsy? No Exploratory-Supanatomy-

What test confirmed diagnosis? Clinical.

(Signed) W. B. Draper, M. D.

4-24-1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 4/28/1930

20 UNDERTAKER J. G. Moran

ADDRESS E. Balto

important. See instructions on back of certificates.

APR 25 1930 C. HAMPSON JONES, M. D.

E-56515

Spec.—8-16-29—L. F. S.—100 Bks.

236049

E 56515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 101-001 5

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Fisher

(a) RESIDENCE NO. 699 N. Side Sp Point Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bethlehem Steel Co

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S Car

PARENTS

10 NAME OF FATHER Alexander Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) S Car

12 MAIDEN NAME OF MOTHER Rose Blackmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S Car

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 25 1930, 19 C. HAMPSON JONES, M. D. Registrar

For NKA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23-1930

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1930, to April 23, 1930, that I last saw h i m alive on April 23, 1930 and that death ocrurred, on the date stated above, at 9 15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Whrre was disease rontrarted if not at place of death?

Did an operation prerede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis X ray; Sputum Typing

(Signed) Hedwig Kaneig, M. D.

4/24, 1930 (Address) Johns Hopkins Hosp.

*State thr Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whrther Accidental, Suiridal, or Homiridal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hunstrn N. C.

DATE OF BURIAL Apr. 25 1930

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1709 Eutaw

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X31

E 56516

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Doran

(a) RESIDENCE NO. 117 Parkwood Av Chestertown Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Doran

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Annie Barrett

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant W J Fuchs
(Address) Chestertown Md

15 Filed 19 C. HAMPSON JONES, M. D.
Registrar

R 25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24-30

17 I HEREBY CERTIFY, That I attended deceased from 1-24, 1930, to 4-24-30, that I last saw h alive on 4-24, 1930 and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Spinal Tuberculosis
Emphysema
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? Yes Date of 4-25-30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical.

(Signed) B Harris, M. D.

4/21 1930 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown Kent Co Md	4/26 30
20 UNDERTAKER Edward Fowlson	ADDRESS 2359 W Balto

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

235-86

E 56517

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 135 E 56517

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Liam Moore

(a) RESIDENCE NO. 150 N Montana ST., WARD El Paso, Texas
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Moore

6 DATE OF BIRTH (month, day, and year) Dec 3-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cattle raiser

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER J. Hanson Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 25 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25-1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 27, 1930, to April 25, 1930, that I last saw h in alive on April 25, 1930 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis, bilat. (1)
Uraemia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 4/7/30

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) H. C. Smith, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D C	Apr 26 1930
20 UNDERTAKER	ADDRESS
Stephens & Jones Lee	1811 Broadway

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56518

CERTIFICATE OF DEATH.

90 E 56518

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2415 Ettinger St. 13-54 (Ward)

2-FULL NAME Robert Moore.

(a) RESIDENCE NO. 2415 Etting St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M.	C.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42.	1	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER R. Moore

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Robinson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mary Jordan

(Address) [illegible]

15 Filed ..... 19 ..... Registrar

25 JAN 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, aforesaid find that said deceased came to death on the day stated above.

(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH was as follows:

Valvular Disease of Heart

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John J. Morrissey M. D.

(Coroner)

1/25 1930 (Address) 3672 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Mem'l Date of Burial 1-27 1930

20 UNDERTAKER George J. A. Gibson ADDRESS 1733 Lo Hilton

Cut DEATH in plain terms, so that it may be very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 56519

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56519

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. Edwin Mack ST., 5-8 WARD)

2-FULL NAME Levering House

(a) RESIDENCE NO. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Dec. 24, 1872

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	58 ?	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington
(State or country) D. C.

PARENTS

10 NAME OF FATHER Luke Mack

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Herney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Records of
(Address) B. C. H.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-23-30

17 I HEREBY CERTIFY, That I attended deceased from 4-13-30, 19..., to 4-23-30, 19...,

that I last saw him alive on 4-23-30, 19...,

and that death occurred, on the date stated above, at 9:15 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) yrs. over 11 mos. 11 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. over 11 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

4-24, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL APR 25 1930 19

20 UNDERTAKER Commissioner Health

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

Dr Grosham 3100 Harford

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56520

E 56520

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1744 Homestead ST., 9-46 WARD)

2-FULL NAME Louis Matthaei

(a) RESIDENCE NO. 1744 Homestead ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or) WIFE of~~ Carrie Matthai

6 DATE OF BIRTH (month, day, and year) Apr 21st 1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis Matthaei

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Eckhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Doris Matthaei (Address) 1744 Homestead St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and ~~year~~) Apr 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1930, to Apr 24, 1930

that I last saw him alive on Apr 24, 1930

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) One yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Mosher, M. D.

Apr 25, 1930 (Address) 3100 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 4/28/1930

20 UNDERTAKER Wm Cook

ADDRESS 129 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 56521

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56521

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 10-14

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W. Morrow

(a) RESIDENCE NO. 1002 E. Biddle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4, 1862?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67?	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER William H. Morrow

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Marry Ann ?

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Records of
(Address) B. C. H.

15 Filed ..... 19 .....

C HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24-30

17 I HEREBY CERTIFY, That I attended deceased from 10-18-27, 19..., to 4-24-30, 19..., that I last saw h... alive on 4-24-30, 19..., and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

4-24, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 4/26/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks. Martin L. Kraft #5652

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56522 ~~E 56522~~

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH University Hospital ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2—FULL NAME Martin L Kraft

(a) RESIDENCE NO. Ellicott City Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna L. Kraft.

6 DATE OF BIRTH (month, day, and year) June 4, 1871

7 AGE Years 59 Months 1 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Kraft.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Leinbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Anna L. Kraft

(Address) Ellicott City Md.

15 Filed 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26-1930

17 I HEREBY CERTIFY, That I attended deceased from April 7— 1930, to April 26 1930, that I last saw h alive on April 26— 1930 and that death occurred, on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma (ascending colon)

(duration) — yrs. 2 mos. — da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 15-1930

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Luther E Easton M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Louis Cem. DATE OF BURIAL Apr. 29 1930

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56523

CERTIFICATE OF DEATH.

38 E 56523

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 612 S. Charles St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie McIntosh

(a) RESIDENCE NO. 612 S. Charles St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of A. Edward McIntosh

6 DATE OF BIRTH (month, day, and year) May 10 th 1910

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	19	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 037

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Portsmouth, Va.

(State or country)

PARENTS

10 NAME OF FATHER James Moody

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Gates Co. Va.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) N. C.

14 Informant Stephen Berman

(Address) 612 S. Charles St.

15 Filed Apr 26, 19 30 RKH Registrar

R 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 10, 1930, to Apr 25, 1930, that I last saw h.. alive on Apr 24, 1930, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Arrhythmia

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) ✓

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) D H Carnes, M. D.

4/25 1930 (Address) 830 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Portsmouth Va — Date of Burial April 26 1930

20 UNDERTAKER J. H. Brown & Son — ADDRESS 108 W. Main

Don should be carefully supplied. All items should be filled in. Fingerprints should be taken if OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56524

CERTIFICATE OF DEATH

129 E 56524

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 13 E. Caroline St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henson

(a) RESIDENCE NO. 13 E. Caroline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna M. Henson

6 DATE OF BIRTH (month, day, and year): April 2 1843

7 AGE: Years 87 Months – Days 22

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver Lumber Wagon 023

(b) General nature of industry, business, or establishment in which employed (or employer): Lumber Business

(c) Name of employer

9 BIRTHPLACE (city or town): Talbot Co

(State or country) Md

PARENTS

10 NAME OF FATHER: Henry Henson

11 BIRTHPLACE OF FATHER (City or town): Talbot Co

(State or country) Md

12 MAIDEN NAME OF MOTHER: Marie Cooper

13 BIRTHPLACE OF MOTHER (city or town): Talbot Co

(State or country) Md

14 Informant: Anna M. Henson

(Address) 13 E. Caroline St

15 Filed ..... 19 ..... NRP Registrar

R 26 1930

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to April 24, 1930, that I last saw h[im] alive on April 24, 1930, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Human Test

(Signed) Richard J. Dolan M. D.

19 (Address) 1514 E Balto

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) Nil

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudenberry

Date of Burial: April 27 1930

20 UNDERTAKER: J Hobbs & Wm Holzapfel

ADDRESS 53 Holzapfel

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56525

CERTIFICATE OF DEATH

+38

E 56525

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH U. S. Marine Hospital

City of Baltimore: (No.) St. 12-51 Ward)

2-FULL NAME William Turner

(a) RESIDENCE NO. Kingston, Jamaica St., Ward

(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	colored	widower

8a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer SS Amelia

9 BIRTHPLACE (city or town)
(State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Hospital Records
(Address) U. S. Marine Hospital

15 Filed ..... 19... G. HAMPSON JONES, M. D. Registrar

R 26 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest autopsy on (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Syphilis (Tertiary)

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. Thomsen C., M. D.

1930 (Address) 263 Orland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	April 26 1930
20 UNDERTAKER E. Leroy Stiffler, Inc.	ADDRESS 125 E. North ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56526

HEALTH DEPARTMENT—CITY OF BALTIMORE E 56526

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 154 Hulen St. 14-20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Harry Deems

3-RESIDENCE NO. 154 Hulen ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Adams Deems

6 DATE OF BIRTH (month, day, and year) Feby 4. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James H. Deems

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary D. Fleet

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mary Adams Deems

(Address) 154 Hulen St

15 Filed ..... 19 ..... Registrar .....

APR 26 1930

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 16th, 1930, to April 24th, 1930, that I last saw him alive on April 24th, 1930, and that death occurred, on the date stated above, at 6.35 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) W. B. Culver Hancock, M. D.

Wes. 1930 (Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Apr 26 1930 DATE OF BURIAL

20 UNDERTAKER John D. Stuteville & Sons ADDRESS 1 W. Eutaw

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 56527

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

167-E 56527

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 206 N Howard St., 77-30 Ward)

2-FULL NAME Rose Klazer

(a) RESIDENCE NO. 206 N Howard St., Ward

(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Singer Sewing Machine Co.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Peter Klazer

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Theresa Klazer

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant John A. Mason
(Address) 3600 E. Baltimore St.

15 Filed ..., 19.. Registrar

R 1 B 1930 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Gas Poisoning Ill.

(duration) Extension yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H C Slade, M. D.

, 19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL April 26, 1930

20 UNDERTAKER John A. Mason — ADDRESS 3600 E. Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56528

CERTIFICATE OF DEATH

X 24 E 56528

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Sydenham Hospital (ST.) 18-16 (WARD)

2—FULL NAME Montgomery Vaughn

(a) RESIDENCE NO. 1130 W. Franklin St (ST.) WARD 9a
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Louise Merritt

6 DATE OF BIRTH (month, day, and year) March 27, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chesterfield Co., Va

PARENTS

10 NAME OF FATHER John Vaughn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) John Vaughn (father) Virginia

15 FILED ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to April 25, 1930,

that I last saw him alive on April 25, 1930

and that death occurred, on the date stated above, at 9 00 p m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningitis
Meningococcic

(duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lumbar puncture

(Signed) Myron B. Sulle, M. D.

4/26, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Petersburg Va — DATE OF BURIAL 4 26 1930

20 UNDERTAKER Samuel S. Hawkins — ADDRESS 1708 Eddy St

important. See instructions on back of certificates.

APR 26 1930

Cor.—10-10-29—A Co.—100 Blks.

E 56529

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56529

CERTIFICATE OF DEATH

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospital 6-9 St., (Ward)

2-FULL NAME Zeby Gillis

(a) RESIDENCE NO. 306 N Amity St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Lucille Gillis

6 DATE OF BIRTH (month, day, and year) Jan 1 1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
41 43		3	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Zett Gillis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Marin Watters

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Dorcella Gillis
(Address) 306 N. amity st

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1930

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find (that said deceased came to death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Cut TB.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Ex Lues

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Blades, M. D.

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

DATE OF BURIAL April 28, 30

20 UNDERTAKER Edward Bryan

ADDRESS 1631 orleans st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REGISTRAR'S SIGNATURE

Par

Spec.—1-10-21—M&T—1500 Bks.

E 56530

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56530

CERTIFICATE OF DEATH.

117

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Md. Gen. Hosp.

CITY OF BALTIMORE: (No. 27-56 ST., WARD)

2-FULL NAME David S. Price Jr.

(a) RESIDENCE NO. 4847 Park Hgts Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Mar. 5-1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	1	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boy.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER David S. Price Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Md.

12 MAIDEN NAME OF MOTHER Mary Elka Siegel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. Md.

14 Informant (Address) Hosp Record

15 Filed APR 26 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-24, 1930, to 4-25-, 1930,

that I last saw h/~~m~~ alive on 4-25-, 1930,

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Purulent Appendicitis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Emolis.

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? At home -

Did an operation precede death? Yes Date of 4-24-30.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Irvin A Crompton M. D.

4/24/30 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 28 1930.
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1627 W. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56531 E 56531

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 McElderry ST. 5-8 WARD)

2-FULL NAME Sarah Woolford

(a) RESIDENCE NO. 1218 McElderry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) March 4 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md.

PARENTS

10 NAME OF FATHER Linton Woolford

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Lucinda .....

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Minnie Wright
(Address) 1218 McElderry St

15 Filed ..... 19 C. HAMPSON JONES, M. D.
Registrar

26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to April 23, 1930

that I last saw h[illegible] alive on April 22, 1930

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency and Arteria Sclerosis (duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. [illegible] Young, M. D.

4/24 1930 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem — DATE OF BURIAL 4-26 1930

20 UNDERTAKER Byron Wright — ADDRESS 1218 McElderry St

Cor.—10-10-29—A Co.—100 Bks.

E 56532

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/E 56532

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 4212 Resterstown Rd (St.) 15-54 (Ward)

2-FULL NAME Jos E. Campbell

(a) RESIDENCE NO. 4212 Resterstown Rd Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary.

6 DATE OF BIRTH (month, day, and year) March 8-1874

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	61		7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) Jas E. Co
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Geo Campbell

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Mrs Dantonia Informant
(Address) 4212 Resterstown Rd

15 Filed ..., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ... M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Apr. 28, 30
20 UNDERTAKER	ADDRESS
Henry Hoeck Long Inc.	301 E Eag

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56533

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 56533

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 N. Central Av ST. 10-14 WARD)

2—FULL NAME Jacob Heilman

(a) RESIDENCE NO. 1112 N. Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 8 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 24 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam fitter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Henry Knight Sons

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Frederick Heilman

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary Emmert

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Adam J. Heilman
(Address) 1112 N. Central Av.

15 Filed C. HAMPSON JONES, M. D.
6 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 15 1929, to April 25 1930, that I last saw him alive on April 24 1930 and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema Lungs

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) E. Gill Hall, M. D.

4-25 1930 (Address) 1631 E. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Apr 28 1930
20 UNDERTAKER	ADDRESS
Henry Hoeck Sons, Inc.	1301 E. Eager

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56534

CERTIFICATE OF DEATH

1930 E 56534

129

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Rayner ave ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Concetta Macciola

(a) RESIDENCE NO. 1810 Rayner ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 40 mos. ds. How long in U. S., if foreign birth? yrs. 40 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Vincent Macciola

6 DATE OF BIRTH (month, day, and year): aug 24, 1862

7 AGE: Years 67 | Months 8 | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Vincent Corvinelli

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Teresa Fruzza

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Claudio Macciola

(Address): 1810 Rayner ave

15 Filed ....., 19 ..... Registrar

APR 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 24/30.

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1930, to April 24, 1930.

that I last saw h~~er~~ alive on April 24, 1930

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Acute Streptococcus

(duration) ✓ yrs. 2 mos. ✓ ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) ✓ yrs. ✓ mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George C. Shannon, M. D.

4/25 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: April 28 1930

20 UNDERTAKER: Frank V. Kipstone

ADDRESS: 2515 E. Baltimore st

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56535

CERTIFICATE OF DEATH

47 E 56535

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1617 Harlem Ave ST. 16-27 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Willis Carey

(a) RESIDENCE NO. 1617 Harlem Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1887 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lottie Ross

(Address) 1617 Harlem Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 2 1930 to April 27 1930, that I last saw h[illegible] alive on April 24 1930 and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible], M. D.

. 19 (Address) 1617 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 4/26/1930

20 UNDERTAKER Mrs. Jas. H. Holland

ADDRESS 1631 Druid Hill

Important. See instructions on back of certificate.

APR 28 1930 HAMPSON JONES, M.D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56536

CERTIFICATE OF DEATH

129 E 56536

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 E.32nd ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis B.Schillinger

(a) RESIDENCE NO. 306 E.32nd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna L.Schillinger

6 DATE OF BIRTH (month, day, and year) May 7 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Philip G.Schillinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Kupp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant L.A.Schillinger(Son)

(Address) Roland Park Apartment

15 Filed APR 26 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 20, 1930, to April 24, 1930

that I last saw him alive on Apr 24, 1930

and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis - Chr. Nephritis, Apoplexia (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) [signature], M. D.

4/26, 1930 (Address) 2020 4. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Apr 26 1930

20 UNDERTAKER John D. Denny

ADDRESS 715 Light St.

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56537 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56537

CERTIFICATE OF DEATH.

84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3904 Springdale Ave ST. 45-64 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Stulman

(a) RESIDENCE NO. 3904 Springdale Ave ST. WARD

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rebecca Stulman

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 65 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: David Stulman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Mattes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Rebecca Stulman

(Address) 3904 Springdale Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/25/30

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to April 25, 1930, that I last saw h[illegible] alive on April 22, 1930, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Wolman, M. D.

4/25, 1930 (Address) 1444 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL: 4-27-1930

20 UNDERTAKER: Jack Laurs 1439 Eastern Ave

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56538

CERTIFICATE OF DEATH.

E 56538

REGISTERED NO. 100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Siegel

(a) RESIDENCE NO. 1605 Cleveland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary Siegel

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Mary Siegel, Wife, 1605 Cleveland Ave

15 Filed 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-29-30

17 I HEREBY CERTIFY, That I attended deceased from 4/26/30 6:30 P.M. to 4/25/30, 19..., that I last saw h[illegible] alive on 4/25/30, 19... and that death occurred, on the date stated above, at 6:50 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) Samuel J. Kaufman M. D.

4/29, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 4/29, 1930

UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56539 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56539

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Linnie Ave (St.) 1568 (Ward)

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Dora Fisher

(a) RESIDENCE NO. 1726 Riggs Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Isadore Fisher

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Krome

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hamol

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harry Fisher

(Address) 1726 Riggs Ave

15 Filed APR 26 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to April 25, 1930, that I last saw h[illegible] alive on April 25, 1930, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral Broncho-Pneumonia

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel J. Kaplan M. D.

1930 (Address) Lutheran Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehren Rosedale

DATE OF BURIAL 4/29 1930

UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 56540

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56540

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 15-68 WARD)

2-FULL NAME Esther Spillman

(a) RESIDENCE NO. 1720 N. Bentleon ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND (of or) WIFE of Joseph Spillman

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lewin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Joseph Spillman 1720 N. Bentleon St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25/30

17 I HEREBY CERTIFY, That I attended deceased from 4/22, 1930, to 4/25, 1930, that I last saw h[illegible] alive on 4/25, 1930, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Hypertension - arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) I. H. Silver, M. D.

4/25 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mooh Road — DATE OF BURIAL 4/27 1930

20 UNDERTAKER Jack Lewis — ADDRESS 1439 Eutaw St

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56541

REGISTERED NO. 129 E 56541

1-PLACE OF DEATH

City of BALTIMORE: (No.) 400 N. Fulton Ave St. (Ward) 20 17

2-FULL NAME Miss Minnie Kahler.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. Home for the Aged of the M. E. Church Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. Lifetime long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10 - 1850

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	80	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jacob Kahler.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Philomena Kingsley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Etta Cushing

(Address) 400 Fulton ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 19 30

17 I HEREBY CERTIFY, That I attended deceased from Nov 27 1929, to April 25, 1930,

that I last saw h.. alive on April 23, 1930,

and that death occurred, on the date stated above, at 5.40a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypocardia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical symptoms

What test confirmed diagnosis?

(Signed) George L. Shannon, M. D.

4/25, 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery Date of Burial April 26 1930

20 UNDERTAKER George J. Smith ADDRESS 110 Saint

APR 28 1930

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56542

CERTIFICATE OF DEATH

129 V E 56542

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 Ramsey ST. 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucy E Crosby

(a) RESIDENCE NO. 1706 Ramsey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Louisville
(State or country) Ky

PARENTS

10 NAME OF FATHER Harian Allen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Grace Allen

(Address) 1706 Ramsey

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 25-30

17 I HEREBY CERTIFY, That I attended deceased from 10 1 19 27 to 4-20 19 30,

that I last saw h[illegible] alive on 4-20 19 30

and that death occurred, on the date stated above, at 3 [illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Obstruction

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) Charles Allen, M. D.

4 26, 19 30 (Address) 54 Hillsdale ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	April 28 1930
20 UNDERTAKER	ADDRESS
F Vernon Keehner	153 Hollins St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56543

90 E 56543

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1417 N. Mound ST. 15-21 WARD)

2—FULL NAME Enoch Lewis Duffin

(a) RESIDENCE NO. 1417 N. Mound ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Addie Duffin

6 DATE OF BIRTH (month, day, and year): Oct 1 1840

7 AGE: Years 89 | Months 6 | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Basil Duffin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Celia Ayares

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs. Victoria Jackson

(Address) 2458 St. Nicholas Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 24 1930

17 I HEREBY CERTIFY That I attended deceased from Apr 12 1930 to Apr 24 1930

that I last saw h[illegible] alive on Apr 24 1930

and that death occurred, on the date stated above, at 10 10 P m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Senility

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. Fabiola, M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery

20 UNDERTAKER: Thomas E. Kelson.

DATE OF BURIAL: April 28 1930

ADDRESS 1303 Pressman St

R 29 1930 [illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56544 — E 56544

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 152 Culver St. 20-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Voelkel

(a) RESIDENCE NO. 152 Culver ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma R. Voelkel

6 DATE OF BIRTH (month, day, and year): May 27-1865

7 AGE: Years 65 — Months 26 Days 27 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sheet Metal

(b) General nature of industry, business, or establishment in which employed (or employer): Worker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Voelkel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Emma R. Voelkel (Address) 152 Culver St.

15 Filed 4-26, 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/23 1930

17 I HEREBY CERTIFY, That I attended deceased from April-11, 1930 to April 22, 1930, that I last saw him alive on April 22, 1930, and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Hemaphlegia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ✓ Date of ✓

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E. Helle Hemmig, M. D.

4/23, 1930 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Apr. 26 1930

20 UNDERTAKER: George L. Schwab — ADDRESS: 501 Fulton Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56545

CERTIFICATE OF DEATH

90 ✓ E 56545

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. Mercy Hospital St., 12-51 Ward)

2-FULL NAME Frank. Farley

(a) RESIDENCE NO. 2414 Maryland Av St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (Write the word)
Male	White	Div.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Contractor
(c) Name of employer

9 BIRTHPLACE (city or town) and
(State or country)

PARENTS

10 NAME OF FATHER Frank. Farley

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary. Murray

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Mrs. John Dunneen
(Address) 2414 Md Ave

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25 - 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Val. Arteriosclerosis

Bronchopneumonia (duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Myocarditis. Palmer Edenson

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. T. Farley, M. D.

Apr. 26 1930 (Address) 1639 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Joseph Cem Texas

DATE OF BURIAL 4/28 1930

20 UNDERTAKER Geo A Farley

ADDRESS Fayette-Fulton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PRINTED BY C. HAMPSON JONES, M.D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56546 100 E 56546

CERTIFICATE OF DEATH.

E 56546

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 222 Colvin ST. 5-8 (WARD)

REGISTERED NO.

(If death occurred in a hospital or, institution, give its NAME instead of street and number.)

2-FULL NAME Birdie Pinkett

(a) RESIDENCE NO. 222 Colvin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Henry Pinkett

6 DATE OF BIRTH (month, day, and year): March 28, 1880

7 AGE — Years: 50 — Months: — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: at home

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Jennie Valentine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mary Brooks (Daughter)

(Address) 1521 Race St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 25 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/20, 1930, to 4/25, 1930, that I last saw her alive on 4/24, 1930, and that death occurred, on the date stated above, at 5A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

4/25, 1930 (Address) 429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cem DATE OF BURIAL: 1930

UNDERTAKER: Wm T Williams ADDRESS: 151 McElderry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 2 7 1930 G. EDGERTON JONES, Registrar

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56547 ✓ 129 E 56547

E 56547

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 N. Duncan ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vaclav Kremstat

(a) RESIDENCE NO. 709 N. Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not known

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Friend

(Address) 709 N Gilmanton Ave

15 Filed ... 19 ... G. LLOYD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25/30

17 I HEREBY CERTIFY, That I attended deceased from January 30, 19 30, to April 25, 19 30, that I last saw him alive on April 25, 19 30, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) ... yrs. 4 mos. ... da.

CONTRIBUTORY (Secondary) Cardio Vascular Renal disease

(duration) ... yrs. ? mos. ... da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Nil

(Signed) Joseph Polowny, M. D.

, 19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL April 28 19 30

20 UNDERTAKER Paul Boucher Son 1906 N Wolfe

ADDRESS

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56548

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 56548

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. South Baltimore General, 24 W. Fayette ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Sprouse

(a) RESIDENCE NO. 920 Burgundy ST., WARD (If non-resident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Sprouse

6 DATE OF BIRTH (month, day, and year) Aug 5 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brick Layer
(b) General nature of industry, business, or establishment in which employed (or employer) 011
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS
10 NAME OF FATHER Wm. T. Sprouse
11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa
12 MAIDEN NAME OF MOTHER Lost Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Minnie Sprouse
(Address) 920 Burgundy

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25-30

17 I HEREBY CERTIFY, That I attended deceased from 4-21, 1930, to 4-25, 1930
that I last saw him alive on 4-25, 1930
and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardio-Renal Vascular Disease (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? yes What test confirmed diagnosis? Physical Findings

(Signed) Joseph Laukaitis, M. D.
19 (Address) South Baltimore General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arrington Pa
DATE OF BURIAL Apr 28 1930

20 UNDERTAKER John Ulrich
ADDRESS 2008 Ericsson

C. HUGHLETT JONES, M. D. Registrar

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56549

CERTIFICATE OF DEATH

109-002

E 56549

REGISTERED NO. 47-53

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ann Coleman

(a) RESIDENCE NO. Edgerton Home ST. WARD

(Usual place of abode) St. George Road (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 6 mos. 27 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Nelson Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Miss Besley

(Address) Edgerton Home

15 Filed ... 19 ... Registrar

27 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1930

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1930, to April 26, 1930, that I last saw her alive on April 26, 1930, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Tonsillitis chronic

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Status lymphaticus (Large thymus) (duration) life yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? Yes Date of Appr. 26, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Samuel McLanahan, M. D.

Apr 26, 1930 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Freedom Cem. DATE OF BURIAL April 28 1930

20 UNDERTAKER John B. Spence ADDRESS 1325 N. Caroline St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56550

REGISTERED NO. 9E 56550

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2119 W North St., 15-68 Ward)

2-FULL NAME Rachel Galperin

(a) RESIDENCE NO. 2119 W North St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Galperin

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	79	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Louis Goffman

11 BIRTHPLACE OF FATHER (city or town) Odessa
(State or country)

12 MAIDEN NAME OF MOTHER Celia Goffman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Meyer Galperin
(Address) 2119 W North St

15 Filed APR 27 1930 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Blank, M. D.

(Address) 1 North Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rawdale

DATE OF BURIAL 4/27 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

Dr Ringrose ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56551

CERTIFICATE OF DEATH.

31 E 56551

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1611 E Lanvale ST. 8-17 WARD)

2-FULL NAME Anna M Dorsey

(a) RESIDENCE NO. 1611 E Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Dorsey

6 DATE OF BIRTH (month, day, and year) Aug 3, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John Gummer

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Victoria Schultz

13 BIRTHPLACE OF MOTHER (city or town) Pa (State or country)

14 Informant William H. Dorsey
(Address) 1611 E Lanvale St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Apl 1, 19 30 to April 26, 19 30

that I last saw h alive on April 26, 30

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis 6 mos

(duration) yrs. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M.D.

4/29/30 (Address) 8 East Lanvale St

*State the Disease Causing Death, or, if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 4/28 19 30

20 UNDERTAKER W. Cook

ADDRESS 1217 E Fayette St

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56552

CERTIFICATE OF DEATH

31 E 56552

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 S. Bond ST. J-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John A Miller

(a) RESIDENCE NO. 413 S. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie Miller

6 DATE OF BIRTH (month, day, and year): Feb 24, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in whirh employed (or employer): 040

(c) Name of employer: Phillips Bros

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mamie Miller 413 S Bond St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1929, to Apr 24, 1930, that I last saw h.. alive on Apr 21st, 1930 and that death occurred, on the date stated above, at 2:20 P m.

The CAUSE OF DEATH* was as follows:

Tuberculus Enteritis

Pulmonary Tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical & Laboratory Exam

(Signed) A. T Reis, M. D.

Apr 30, 1930 (Address) 24 S. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: 4/27 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 E Pratt St

Spec.—8-16-29—L. F. S.—100 Bks.

235-50 S

E 56553

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56553

114

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. G-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bernard Poehler

(a) RESIDENCE NO. 1630 Gorsuch Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen E Poehler

6 DATE OF BIRTH (month, day, and year) Sept 15 1889 Baltimore

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER John Poehler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER Frances Fortman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 27 1930 19 KLK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25-30

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1930, to April 25, 1930, that I last saw h[illegible] alive on April 25, 1930 and that death occurred, on the date stated above, at 2 05 P. m.

The CAUSE OF DEATH* was as follows:

Gastroenteritis

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Chronic alcoholism

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. S. Munroe, M. D.

4/25, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 4/28/1930

20 UNDERTAKER Wm Cook 1207 St

ADDRESS Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56554

188-103

E 56554

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Union Mem. Hosp. St. 17-51 (Ward)

2-FULL NAME Garland Sinclair

(a) RESIDENCE NO. 2625 Bernard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 27-1920

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	10	0	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Edgar Sinclair

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Maud Mooney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs Maude Sinclair
(Address) 2625 Bernard St

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
boy ran into front fender of auto backing into garage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? date of

Was there an autopsy? no

What test confirmed diagnosis? Surgical & X-ray

(Signed) H J Traut, M. D.

Apr 26 1930 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
St Marys (Hampden) Pa

DATE OF BURIAL 4/29/1930

20 UNDERTAKER
Wm Cook

ADDRESS 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 27 1930

Spec.—1-30—M. & T.—250 Bks.

E 56555 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56555

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 14-20 St., 14 WARD)

2-FULL NAME Mary Eleanor Harper

(a) RESIDENCE NO. St Vincents Infant Asylum St., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25 1927

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
2	5 3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Harper

11 BIRTHPLACE OF FATHER (City or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER E. Callahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Harper, Relative (Address)

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24/30

17 I HEREBY CERTIFY, That I attended deceased from 3-28, 1930, to 4-24, 1930, that I last saw her alive on 4-24, 1930, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH[a] was as follows:

Broncho pneumonia

(duration) ... yrs. 1 mos (approx) ... ds.

CONTRIBUTORY (Secondary) Rheumatic cardiovascular disease (duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Geyko, M. D.

4/24, 1930 (Address) Mercy Hospital.

[a]State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL 4/27, 1930

20 UNDERTAKER Jno J Fahey Sons — ADDRESS 1318 Light St

THIS IS VERY IMPORTANT. See instructions on back of certificate.

APR 27 1930 HARRY JONES, M.D.

Spec.—1-12-23—M&T—500 Blks.

E 56556

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 56556

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1506 Mount St. 15-21 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie J. Nelson

(a) RESIDENCE NO. 1506 Mount ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos D Nelson

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE: Years 45 | Months | Days | If LESS than 1 day, ... hrs or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country): Brunswick Va

PARENTS
10 NAME OF FATHER: R H Joyner
11 BIRTHPLACE OF FATHER (city or town) (State or country): Brunswick Va
12 MAIDEN NAME OF MOTHER: Elizabeth Turner
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Brunswick Va

14 Informant: Thos D Nelson
(Address): 1506 N Mount St

15 Filed ..... 19 ..... Registrar

R 2 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 25 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/22, 1930, to 4/25, 1930,
that I last saw h[er] alive on 4/25, 1930
and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:
Pleurisy & Lung
Infection Pneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Robert Wells, M. D.
4-27 1930 (Address) 43 E Oliver

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brunswick Virginia
DATE OF BURIAL: 4-27 1930

20 UNDERTAKER: Frank T Saunders, 78 N Bridle
ADDRESS

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E Compbell Hanover what St

E 56557 HEALTH DEPARTMENT--CITY OF BALTIMORE 24 E 56557

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3000 Stafford ST 20-10 WARD)

2-FULL NAME Philemon G. Morris

(a) RESIDENCE NO. 3000 Stafford St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 9. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles R Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Mary Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Charles R Stafford (Address) 3000 Stafford St

15 Filed ..... 19 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26. 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 26, 1930, to April 26 1930, that I last saw him alive on April 26, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) ..... yrs. 1 mos 0 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Cambridge M. D.

April 26 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL Apr 28 1930

20 UNDERTAKER W. Cook — ADDRESS 1219 E Fayette St

FROM IS very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56558 E 56558

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3104 Cliftmont St. Ward 8)

2-FULL NAME Marie Burdette

(a) RESIDENCE No. 3104 Cliftmont Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alphonso Burdette

6 DATE OF BIRTH (month, day, and year): Aug 15 - 99

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
30	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Robert T Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va.

12 MAIDEN NAME OF MOTHER: Anne Daniels

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Alphonso R Burdette 3104 Cliftmont ave

15 Filed ..... 19 ..... Registrar

C. HAYDEN JONES, M. D.

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 24 1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1926, to Apr 24, 1930, that I last saw h alive on Apr 24, 1930 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary chronic active all of lobes both lungs

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam & Sputum

(Signed) E. H. Donaldson, M. D.

, 19 (Address) 817 Park. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Hanston 3104 Kentucky

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

New Bath April 28-30

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56559

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56559

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 27-18 ST., WARD)

2-FULL NAME Emma Barker

(a) RESIDENCE NO. 415 E. Lake Ave. ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81			

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER John Barker

11 BIRTHPLACE OF FATHER (city or town) England

(State or country)

12 MAIDEN NAME OF MOTHER Margaret Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25-30

17 I HEREBY CERTIFY, That I attended deceased from 4-15-30, 19, to 4-25-30, 19, that I last saw her alive on 10:30 A., 19, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic over 10 yrs. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home & here

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H McLean, M. D.

(Address) Balto. City Hosp. 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkridge Md DATE OF BURIAL April 28 30

20 UNDERTAKER Franklin W Seitz ADDRESS 709 W 33 St.

APR 1930 BALTIMORE M. D.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 56560

E 56560

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) President Hospital ST., 11-20 WARD)

2—FULL NAME John Anthony

(a) RESIDENCE NO. 532 Robert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie

6 DATE OF BIRTH (month, day, and year) ? 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Polisher

(b) General nature of industry, business, or establishment in which employed (or employer) O&L

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Daisy Robenia

(Address) 532 Robert St

15 Filed 2 7 1930, 19 RPK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24-30

17 I HEREBY CERTIFY, That I attended deceased from 4-17-, 1930, to 4-24, 1930

that I last saw h alive on 4-24-, 1930

and that death occurred, on the date stated above, at 11.15 a m.

The CAUSE OF DEATH* was as follows:

Uremia Nephritis

Cardio-Vascular

Renal Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. Graham, M. D.

4/27 1930 (Address) Woodbourne Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 4/27/1930

20 UNDERTAKER Mrs. Geo. H. Holland — ADDRESS 1631 Druid Hill Ave

Important: See instructions on back of certificate.

Spec. 1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 E 56561

E 56561

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3726 Park Heights St. 15-58 WARD)

2-FULL NAME Marie Palmisano

(a) RESIDENCE NO. 3726 Park Heights ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Salvatore Palmisano

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) ... (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) ?

14 Informant Mrs. Anzovella (Address) 3726 Park Heights

15 Filed ... 19 ... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25-30

17 I HEREBY CERTIFY, That I attended deceased from Jan ..., 19 27, to April 25, 1930, that I last saw h[illegible] alive on April 28, 1930, and that death occurred, on the date stated above, at 6.05 m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Waranick, M. D.

4/28, 1930 (Address) 3429 Chestnut, Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL 4/28/30

20 UNDERTAKER Mary T. Puth ADDRESS 1235 Hanford Av.

APR 27 1930

Spec.—8-16-29—L. F. S.—100 Bks.

Gaugh ✓

236269

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56562

CERTIFICATE OF DEATH

X 90 E 56562

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bowen Gaugh

(a) RESIDENCE NO. Oella Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov-10-1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Glen Gaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Paddy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) Johns Hopkins Hospital

15 Filed APR 27 1930 19 R.W.K. Registrar

HAMILTON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April-27-1930

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to April 27, 1930, that I last saw h. im alive on April 27, 1930 and that death occurred, on the date stated above, at 4.20 A m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

Rheumatic heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benjamin E. Hodge, M. D.

4-27, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oella Cemetery	Apr. 29, 19 30
20 UNDERTAKER	ADDRESS
Easton Sons	Ellicott City

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56563

E 56563

CERTIFICATE OF DEATH

32

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Provident Hospital ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Hayes

(a) RESIDENCE NO. 674 Penn Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 29 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Peter Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Hayes

(Address) 674 Penn Alley

15 Filed APR 27 1930 C. HAMPSON LEWIS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26-30

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to April 26, 1930

that I last saw h.. alive on April 26, 1930

and that death occurred, on the date stated above, at 12:30 P.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 4-27 1930

20 UNDERTAKER Hunt Eastern

ADDRESS 946 Eutaw

Important: See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

236200
E 56564

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56564

CERTIFICATE OF DEATH

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JONES HOPKINS HOSPITAL ST., 14-15 WARD)

2—FULL NAME Fannie Bailey

(a) RESIDENCE NO. 1501 Madison ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N W

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Charles Lemacr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dora Hungerford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JONES HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24-1930

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to April 24, 1930, that I last saw her alive on April 30, 1930 and that death occurred, on the date stated above, at 11 10 P m.

The CAUSE OF DEATH* was as follows:

Hypertension

Myocardial insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) Hedwig Koenig, M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

20 UNDERTAKER Hunt Undertaking

DATE OF BURIAL 4-29 1930

ADDRESS 916 Eutaw

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56565 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56565

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 14-30 ST. AND)

2-FULL NAME Jeff Carrington

(a) RESIDENCE NO. 2124 Brunt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

12-4-29

6 DATE OF BIRTH (month, day, and year) May 10, 1869?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60?	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O H O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Henry ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of B. C. H.

(Address)

15 Filed APR 27 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25-30

17 I HEREBY CERTIFY, That I attended deceased from 12-4-29, 19..., to 4-25-30, 19..., that I last saw him alive on 4-25-30, 19..., and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Acute

(duration) 1? yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

4-25 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 4-29 1930

20 UNDERTAKER Dant Eaton

ADDRESS 916 Carey

Spec.—1-30—M. & T.—250 Blks.

E 56566 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56566

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 Sarah Ann ST.) 18-76 (WARD)

2-FULL NAME Minty Hinton

(a) RESIDENCE NO. 915 Sarah Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Washington Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Annie Hamilton

(Address) 903 Sarah ann St

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 25/30

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1930, to Apr. 25, 1930,

that I last saw h.... alive on ....., 19....,

and that death occurred, on the date stated above, at 2.15 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease Heart

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Robt E. Wagner M. D.

4/28, 1930 (Address) 1706 Edmondson Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem.

DATE OF BURIAL 4-27 1930

20 UNDERTAKER Daniel Easton

ADDRESS 716 Pa ave

IMPORTANT: See instructions on back of Certificate.

FEB 7 1930 HAMPSON JONES, M.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56567

188-1932 E 56567

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1169) West Balto St., (Hosp.) Ward 6

2-FULL NAME John Slitzer

(a) RESIDENCE NO. 637 N. Bentalou St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
m	w	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie L. Slitzer

6 DATE OF BIRTH (month, day, and year) Dec 30 - 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	51	3	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter Finisher
(b) General nature of industry, business, or establishment in which employed (or employer) 86
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Balto City

PARENTS

10 NAME OF FATHER John Slitzer

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Ford

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Sallie Lenora Slitzer
(Address)

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Fract Skull
Ran down by auto at
entrance in while endeavoring
to catch street car (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? North + Bentalou

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Dr Duncan

(Signed) L Frame, M. D.

4-26 1930 (Address) 3489 E Eldy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	4-27 1930
20 UNDERTAKER Arnold Custard	ADDRESS 716 Ba ave

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56568

CERTIFICATE OF DEATH.

74-001 E 56568

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 317 Loneys Lane St., 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Hrubes

(a) Residence No. 317 Loneys Lane St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna Hrubes

6-DATE OF BIRTH (month, day and year) 1858

7-AGE. 72 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Austria

PARENTS.

10-NAME OF FATHER. Frank Hrubes

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Austria

12-MAIDEN NAME OF MOTHER. Mont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Austria

14-(Informant) Bro. Gynning (Daughter)

(Address) 1445 Reynolds St

Filed APR 27 1930 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 26 30

17-I HEREBY CERTIFY, That I attended deceased from March 1 1930 to April 25 1930

that I last saw her alive on April 25 1930

and that death occurred, on the date stated above, at 526 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William L. Russell M. D.

April 27, 1930 (Address) 806 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross Cem. aa

DATE OF BURIAL. April 28, 1930

20-UNDERTAKER. Margaret D. Flynn

ADDRESS 1422 Light St.

Instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

56569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 E 56569

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St. 23-34 Ward)

2-FULL NAME John Thomas Edwards, Jr.

(a) RESIDENCE NO. 18 E. Fort Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 11 mos. 18 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) May 7, 1919

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	10	11	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Thomas Edwards Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Amelia Floyd.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant (Amelia Edwards, (mother)
(Address) 18 E. Fort Ave.

15 Filed ....., 19.... Registrar

APR 27 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Burned about the body from lighted gas range.
Occidental Death.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? 18 E. Fort Ave. April 25, 1930
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry.

(Signed) Otto M. Leonhardt, M. D.
4/26 1930 (Address) 1017 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL Apr. 28 1930

20 UNDERTAKER Margaret A. Flynn

ADDRESS 1422 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—[illegible] Bks.

656570

656570 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 16-61

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2330 W. Lanvale St. (WARD)

2-FULL NAME H. Berkeley Morton

(a) RESIDENCE NO. 2330 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 4 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Black Morton

6 DATE OF BIRTH (month, day, and year) Dec. 7, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman & Mgr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer West Disinfecting Co

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Henry S. Morton

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Helen M. Levering

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs Grace B. Morton

(Address) 2330 W. Lanvale St.

15 Filed APR 28 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to April 26, 1930, that I last saw him alive on April 25, 1930, and that death occurred, on the date stated above, at 2.10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) yrs. 11 mos 20 ds.

CONTRIBUTORY (Secondary) Carcinoma of Colon

(duration) yrs. 11 mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes No Date of May 7-1929

Was there an autopsy?

What test confirmed diagnosis? Examination of Tumor

(Signed) G W Billups, M. D.

, 19 (Address) 2224 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL Apr 28 1930

20 UNDERTAKER Wm J Tickner & Sons — ADDRESS North Ave

HOW is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56571

101-001

R 56571

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 E Biddle ST. 10-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura Martin

(a) RESIDENCE NO. 1319 E Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Martin

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years 52; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unk

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Elzabeth Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Lorella Robinson

(Address): 1319 E Biddle St

15 Filed APR 28 1930 19 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 25-30

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930 to April 25 1930,

that I last saw h alive on April 25, 1930

and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Croupous Pneumonia

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Edwin S. Allen, M. D.

3/26 1930 (Address) 508 Somerset St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

UNDERTAKER: John H. Toadvine

DATE OF BURIAL: Apr 28 1930

ADDRESS: 1027 Round Hill

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56572

CERTIFICATE OF DEATH

E 56572

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 3102 Parkside Drive St. 26-H Ward)

2-FULL NAME Catherine Philipp

(a) RESIDENCE NO. 3102 Parkside Drive St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Philipp

6 DATE OF BIRTH (month, day, and year) May 3/1857

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	72	11	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Conrad Lentz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Ochs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Henry Philipp
(Address) 3102 Parkside Drive

15 Filed ..., 19... C. HARRISON JONES, M. D.
Registrar

R 26 1930 per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy
(History of Paralysis 7 yrs.)

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

4/26/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	April 28 1930
20 UNDERTAKER	ADDRESS
E. Schulman & Son	1029 Hanover St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 56573

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 56573

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 23-34 WARD

2-FULL NAME Mr Edward Young

(a) RESIDENCE NO. 1518 Light ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Viola

6 DATE OF BIRTH (month, day, and year): Oct. 6-1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Edw Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Rich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mrs Viola Young 1518 Light

15 Filed ... 19 ... Per ... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-26 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-14 1930 to 4-26 1930.

that I last saw him alive on 4-26 1930

and that death occurred, on the date stated above, at 6.10 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? X ray of chest

(Signed) Ernest Epstein Jr. M. D.

19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: Capsid 1930

20 UNDERTAKER: J. H. McCully

ADDRESS: 128 E Hoffman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56574

90 E 56574

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.....ST. 19-27 WARD)

2-FULL NAME Mary Forrest

(a) RESIDENCE NO. 1709 W. Franklin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 61 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer St Mary's City

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Hooper 0

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of
(Address) Balto. City Hospitals

15 Filed 1936 19 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26-30

17 I HEREBY CERTIFY, That I attended deceased from 4-14-30, 19..., to 4-26-30, 19...,

that I last saw her alive on 4-26-30, 19...,

and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

(a) Bronchitis, acute

Cardiac hypertrophy

(duration) ...yrs. over 10 mos. ...ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

(duration) ...yrs. over 10 mos. ...ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin W. McLean, M. D.

4-26, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Cath Cem

DATE OF BURIAL Apl 29 19 30

20 UNDERTAKER Simon A. Hennessey

ADDRESS 578 a Bridge St.

FROM A very important See instructions on back of certificate

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓

E 56575

E 56575

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary, W. 2nd Prison) ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Delaney

(a) RESIDENCE NO. 1410 Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28, 1905

7 AGE — Years: 25 — Months: - — Days: 28 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butler 070

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): South Boston Va.

PARENTS

10 NAME OF FATHER: William Delaney

11 BIRTHPLACE OF FATHER (city or town) (State or country): So. Boston Va.

12 MAIDEN NAME OF MOTHER: Iris Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): So. Boston Va.

14 Informant: Pearl Lee

(Address) 1410 Maryland Ave.

15 Filed 4-28, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to April 25, 1930, that I last saw h[illegible] alive on April 25, 1930 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 11 mos. 19 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Examination

(Signed) Chas W Edmonds M. D.

, 19 (Address) 2746 Alameda Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bluefield Springs Va

DATE OF BURIAL: 4-28 1930

20 UNDERTAKER: Dennis Easton

ADDRESS: Race

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 56576 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56576

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2014 Kelly Ave St. 27th Ward) Mt. Washington

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dollie Cradle

(a) RESIDENCE NO. 2014 Kelly Ave ST. Mt. Washington WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard

6 DATE OF BIRTH (month, day, and year): ? 1876

7 AGE: Years 54; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Richard Cradle (Address) 2014 Kelly Ave

15 Filed APR 28 1930 HAMILTON JONES, R. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 25 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929 to April 25, 1930,

that I last saw h[illegible] alive on April 25, 1930

and that death occurred, on the date stated above, at 8:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. C. Johnson, M. D.

, 19 (Address) 2329 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 4/28/1930

20 UNDERTAKER: Jno. Geo. H. Holland

ADDRESS: 1638 Druid

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56577

CERTIFICATE OF DEATH.

100-001

E 56577

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp. St. 13-57 (WARD)

2-FULL NAME James Baker

(a) RESIDENCE NO. 3525 Clipper Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Baker

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record
(Address)

15 Filed ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27-30

17 I HEREBY CERTIFY, That I attended deceased from 4-21, 1930, to 4-27, 1930, that I last saw him alive on 4-27, 1930, and that death occurred, on the date stated above, at 5-30 a. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic hypertrophy

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Pumpkins, M. D.

4-27, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Apl 30, 30

20 UNDERTAKER Edwards & Son — ADDRESS 5617 Belair Rd

APR 28 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 56578

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 56578

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 12-51

CITY OF BALTIMORE: (No. University Hosp. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael Althoff

(a) RESIDENCE NO. 2927 Huntington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Linda Althoff.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Longshoreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Linda Althoff

(Address) 2927 Huntington Ave

15 Filed APR 28 1930 Registrar. JONES M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27/30.

17 I HEREBY CERTIFY, That I attended deceased from 4/25, 1930, to 4/27, 1930, that I last saw him alive on 4/27, 1930 and that death occurred, on the date stated above, at 10:05 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia. 2d.

Pleurisy with effusion 1st.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical findings.

(Signed) Henry F. Helrich, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	April 30 1930
20 UNDERTAKER	ADDRESS
Schnorr Bros	3615 Eastern Ave

For

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56579

E 56579

CERTIFICATE OF DEATH

REGISTERED NO. 12-44

1—PLACE OF DEATH

CITY OF BALTIMORE (No. Union Mem. Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julius W. Stuart

(a) RESIDENCE NO. 413 Bretton Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced (or WIFE of) HUSBAND of Gelert Stuart

6 DATE OF BIRTH (month, day, and year) July 30 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) Law Clerk.

(c) Name of employer B + O.

9 BIRTHPLACE (city or town) (State or country) Waterborough So. Carolina

PARENTS

10 NAME OF FATHER Benjamin Rhett Stuart

11 BIRTHPLACE OF FATHER (city or town) (State or country) So. Carolina

12 MAIDEN NAME OF MOTHER Emma Thomson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) So. Carolina

14 Informant Mrs. Gelert Stuart

(Address) 413 Bretton Place

15 Filed ....., 19 ..... Registrar C. HERBERT JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1930

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1930, to April 26, 1930, that I last saw h.i.m alive on April 26, 1930 and that death occurred, on the date stated above, at 8:45 P m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis

Acute dilatation of heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary edema (duration) yrs. mos. 6 hrs.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs + symptoms

(Signed) Nicholas Lanspeard, M. D.

Apl 26 1930 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton Md apl. 28 1930

DATE OF BURIAL

20 UNDERTAKER John D. Mitchell Sons 190 Eastern Place

ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

E 56580

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56580

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 131 N. Fulton Ave ST. 19-27 (WARD)

2-FULL NAME Doris May Myers

(a) RESIDENCE NO. 131 N Fulton Ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Oct 13, 1920

7 AGE — Years: 9 — Months: 6 — Days: 12 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Howard F. Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Florence Mayzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Wm Koegler 131 N Fulton Ave

15 Filed R 2 8 1930 C. 19 Par

H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 25 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to April 25, 1930, that I last saw her alive on April 24, 1930, and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Pul Tuberculosis

(duration) yrs. 1 mos. 24 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

4/25, 1930 (Signed) Wm A. O'Neill M. D.

(Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL 4/28/30

20 UNDERTAKER: H. A. Wehrheit

ADDRESS 1800 W Balto

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 56581

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56581

REGISTERED NO.

1-PLACE OF DEATH HERMAN THOMAS 90

CITY OF BALTIMORE: (No. 500 E Pratt ST. 4-6 WARD)

2-FULL NAME Inf Charles Herbert

(a) RESIDENCE NO. 500 E Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed~~, or Divorced, (write the word): Divorced

5a ~~If married, widowed~~, or divorced HUSBAND of (or) WIFE of: divorced

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 62 yrs. Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer): Watching Shop

(c) Name of employer: J. R. Fordelo

9 BIRTHPLACE (city or town) (State or country): Cambridge Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: E. U. Kelly MD

(Address): 1 E Baltimore

15 Filed ..... 19 ..... Registrar: C. HAYDON JONES, M.D.

APR 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 24/30

17 I HEREBY CERTIFY, That I attended deceased from Mar 27, 1930 to Apr 24, 1930

that I last saw him alive on Apr 15, 1930

and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows: Myocarditis

Shortness of breath

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hypertrophy Heart

Asthma of 5 years

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Edward Keller M.D.

, 19 (Address) Maryland Bank Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel cemet

DATE OF BURIAL: Apr 28-30

20 UNDERTAKER: Wendell J Dippel

ADDRESS: 3008 Eden st

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 56582

HEALTH DEPARTMENT—CITY OF BALTIMORE

112 E 56582

CERTIFICATE OF DEATH

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 246 S Bethel St. 3-4 Ward)

2-FULL NAME Mat. W Arthur Riley

(a) RESIDENCE NO. 246 S Bethel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife Anna Riley

6 DATE OF BIRTH (month, day, and year): February 11 1859

7 AGE: Years 71. Months 2. Days 13 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town):
(State or country): Virginia

PARENTS

10 NAME OF FATHER: Richard Riley

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Sibria Whitehead

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Virginia

14 Informant: Anna Riley
(Address): 246 S Bethel St

15 Filed 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Diarrhea
Acute Gastritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. C. Hodges M. D.

19 (Address) 1430 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Grove — DATE OF BURIAL: April 30 1930

20 UNDERTAKER: Kundell & Kippel — ADDRESS: 320 E Lant

Spec.—1-30—M. & T.—250 Blks.

E 56583 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56583

100-01

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 1-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Redgell

(a) RESIDENCE NO. 819 S. Potomac ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Leo Homer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucinda ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Record

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24-30

17 I HEREBY CERTIFY, That I attended deceased from 4-19, 1930, to 4-24, 1930,

that I last saw h.. alive on 4-24, 1930,

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Prolapse rectum

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 4-19-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Pumphrey, M. D.

4-24, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel

DATE OF BURIAL April 28 1930.

20 UNDERTAKER Kendall & Keppel

ADDRESS 300 S. Calvert

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56584

CERTIFICATE OF DEATH

101-001

E 56584

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 521 N. Bruce St. (Ward) 19-27

2-FULL NAME Chas A Haycock

(a) RESIDENCE NO. 521 N. Bruce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Haycock

6 DATE OF BIRTH (month, day and year): Aug 24 1884

7 AGE: Years 35 Months 8 Days 3 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Md.
(State or country)

PARENTS

10 NAME OF FATHER: Jas. Haycock

11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)

12 MAIDEN NAME OF MOTHER: Hickman

13 BIRTHPLACE OF MOTHER (city or town): Md.
(State or country)

14 Informant: Emma Haycock
(Address): 521 N. Bruce

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

APR 24 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No Regular

What test confirmed diagnosis? .....

(Signed) H. Bolton Smith M. D. Coroner

(Address) 4 Apr 24

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dulaney's Gdns Havre de Grace Md

DATE OF BURIAL: April 28th 1930

20 UNDERTAKER: A. Jones

ADDRESS: 111 S. Eden

Spec.—8-16-29—L. F. S.—100 Bks.

SEWELL

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56585

154-001

E 56585

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital

REGISTERED NO. 12-51

CITY OF BALTIMORE: (No. Sanbard + Greene ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence M. Sewell

(a) RESIDENCE NO. 324 W. 29 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 22 da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 5-1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Filbur R. Sewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. McDowell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Filbur R. Sewell

(Address) 324 E. 29th St.

15 Filed ____, 19__ C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27-1930

17 I HEREBY CERTIFY, That I attended deceased from April, 1930, to April 27, 1930, that I last saw h[illegible] alive on April 27, 1930 and that death occurred, on the date stated above, at 1:50 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 da.

CONTRIBUTORY (Secondary) Hydrocephalus

(duration) yrs. mos. 21 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Walter B. Johnson, M. D.

April, 19 30 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	April 28 1930
20 UNDERTAKER	ADDRESS
Horace H. Burgee	363 Falls Road

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56586

CERTIFICATE OF DEATH

E 56586

REGISTERED NO. 46

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2411 Orleans ST., 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna M. Silverson

(a) RESIDENCE NO. 2411 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Silverson

6 DATE OF BIRTH (month, day, and year) Aug. 28 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Dennis Mc. Sweeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Chas. Silverson (Address) 2411 Orleans St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23/30

17 I HEREBY CERTIFY, That I attended deceased from March 2nd, 1930, to 4/25th, 1930, that I last saw h.er alive on 4/26th, 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Left Breast

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of about 3/7/30

Was there an autopsy? no

What test confirmed diagnosis? Examination of Expt

(Signed) H. J. Tankersley, M. D.

, 19 (Address) 119 N. Mechanic St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL April 29 1930

20 UNDERTAKER Jos. F. Herr ADDRESS 156 N. Luzerne ave.

Spec.—1-30—M. & T.—250 Bks.

E 56587

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 56587

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO. 27-55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 4. ST. WARD

2-FULL NAME Joseph Chessler

(a) RESIDENCE NO. 6214 Wallis Ave WARD

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 5.0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of Rebecca B. Chessler

6 DATE OF BIRTH (month, day, and year) Mch. 15, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
79	69	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER ? Chessler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harry Chessler

(Address) 6214 Wallis Ave

15 Filed 2 6 1930 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1930, to April 27, 1930, that I last saw him alive on April 27, 1930, and that death occurred, on the date stated above, at 8. a.m. p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia - bilateral

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel J. Taubin, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 4/ 1930

20 UNDERTAKER David Sondheim

ADDRESS 518-20 W. Mo Royal Ave

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56588

CERTIFICATE OF DEATH

14-001

E 56588

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 415. N. East ave. ST. 6-11 WARD)

2—FULL NAME Joseph Bochardy

(a) RESIDENCE NO. 415. N. East Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Angela Bochardy

6 DATE OF BIRTH (month, day, and year): June 9-1855

7 AGE: Years 75. Months 10 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lithographer

(b) General nature of industry, business, or establishment in which employed (or employer): S. Kirk & Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): France

PARENTS

10 NAME OF FATHER: Mr. Esmond

11 BIRTHPLACE OF FATHER (city or town) (State or country): France

12 MAIDEN NAME OF MOTHER: Mrs. Esmond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): France

14 Informant: Benj. J. Bochardy

(Address): Fairdale Md.

15 Filed APR 28 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 25-1930

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1930, to April 25, 1930, that I last saw h.i.m alive on April 25, 1930 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia, Senility (duration) Arterio sclerosis past 10 yrs or more yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cessation of Cardiac & respiratory act

(Signed) W. A. Anderson M. D.

Apr. 26, 1930 (Address) 2419 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: April 29th 1930

20 UNDERTAKER: Fred. A. Krebs & Son

ADDRESS: 723 S. Hanover St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 86-002

E 56589

CERTIFICATE OF DEATH

E 1-56589 DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Lillian M. Tucker

(a) RESIDENCE NO. 273 St. Helena Ave. ST. Dundalk WARD Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lew F. Tucker

6 DATE OF BIRTH (month, day, and year) Aug 29 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) House-wife

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Charles Walsh

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Strobb

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Lew F. Tucker

(Address) 273 St Helena

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to April 26, 1930, that I last saw her alive on April 26, 1930 and that death occurred, on the date stated above, at 6-55 P m.

The CAUSE OF DEATH* was as follows:

Acute mastoiditis

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) ....yrs. ....mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Apr. 26, 1930

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thos. R. O'Rourk, M. D.

Apr. 26 1930 (Address) 104 W Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 29 1930
20 UNDERTAKER John H. Denny	ADDRESS 713 Light St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56590

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56590

CERTIFICATE OF DEATH

REGISTERED NO. 45

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Light ST. 23-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura C. Garrison

(a) RESIDENCE NO. 1125 Light ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Garrison

6 DATE OF BIRTH (month, day, and year) July 18 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Emmettsburg Md

PARENTS

10 NAME OF FATHER Frederick Krause

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ann E Beaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Ella E Stone (Sister)

(Address) 1125 Light St

15 Filed APR 28 1930 CHAMPION JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25. 1930.

17 I HEREBY CERTIFY, That I attended deceased from 3.27.30. 19..., to Ap. 25. 19 30

that I last saw her alive on Ap. 25 19 30

and that death occurred, on the date stated above, at 6. P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of intestine

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical only

(Signed) Philip B. Fowler M. D.

4.28.30 19 (Address) Philip B. Fowler

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baldwin Mem. Church Cem. Emmettsburg Md

DATE OF BURIAL April 28 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec.—1-30—M. & T.—250 Blks.

E 56591

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56591

CERTIFICATE OF DEATH.

129

REGISTERED NO. 3552

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital (St.) (Ward)

2-FULL NAME E. Carrella Benjamin

(a) RESIDENCE NO. 4058 Hickory Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Charles L Benjamin

6 DATE OF BIRTH (month, day, and year) April 6 1884

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer) home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Marley Md

PARENTS

10 NAME OF FATHER Wyatt Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Sarah E Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Marley Md

14 Informant Mrs Rogers Williams (Brother)

(Address) 476 S. Bentalou st

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-23, 1930, to 4-25, 1930, that I last saw her alive on 4-25, 1930, and that death occurred, on the date stated above, at 825 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Hypertension. Chron. nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical tests

(Signed) Samuel J Hankin, M. D.

4-25, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cemetery Hampden

DATE OF BURIAL April 28 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

TION IF very important. See instructions on back of certificate

4-28-1930 HAMPTON JONES, M. D.

RMK

Spec.-7-17-26—A Co.—200 Bks.

36592

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56592

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2925 Belmont Ave. St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara V. Volk.

(a) RESIDENCE NO. 2925 Belmont Ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 9 mos. 29 ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of John Volk.

6 DATE OF BIRTH (month, day, and year) June 28-1872.

7 AGE. Years	Months	Days	IF LESS than 1 day hrs. or min.
57	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER William Della.

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hester Lawton.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Volk. (Address) 2925 Belmont Ave.

15 Filed APR 28 1930 19 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-13- 1929, to 4-26 1930, that I last saw her alive on 4-26 1930, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Clinical Signs

(Signed) James Brown, M. D.

19 (Address) 705 Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery. Date of Burial April 29-1930.

20 UNDERTAKER Charles J. Schwab. ADDRESS 505 N. Monroe St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56593

HEALTH DEPARTMENT—CITY OF BALTIMORE

88 E 56593

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 Eastern Ave. ST. 3-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Van Osten

(a) RESIDENCE NO. 1024 Eastern Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Known

6 DATE OF BIRTH (month, day, and year): January 15, 18[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Broom maker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Bernard VanOsten

11 BIRTHPLACE OF FATHER (city or town) (State or country): Holland

12 MAIDEN NAME OF MOTHER: Amelia Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Amelia Kleissler (Sister)
(Address): 1024 Eastern Avenue

15 Filed APR 28 1930 HANSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to April 25, 1930, that I last saw him alive on April 25, 1930, and that death occurred, on the date stated above, at 7.00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Voburka M. D.

Apr 26 1930 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: Apr. 28. 1930

20 UNDERTAKER: Henry Sander & Sons Inc.

ADDRESS: Baltimore St. & Broadway.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56594 ✓ 46 ✓ E 56594

E 56594

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 46-44

CITY OF BALTIMORE: (No. ..... ST. 16 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Henry L. de Zeng (Anna)

(a) RESIDENCE NO. 737 S. Main St., Geneva, N.Y. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. / mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry L. de Zeng

6 DATE OF BIRTH (month, day, and year) Oct. 8, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	6 7	18 19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Adolph C. Meyer

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country) Stettmann

12 MAIDEN NAME OF MOTHER Florence Hellmann

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Hospital Records

(Address)

15 Filed ..... A. ..... C. 19..... Registrar

R 26 1930 C. HUNGERFORD, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1930, to April 27, 1930 that I last saw h[er] alive on April 27, 1930 and that death occurred, on the date stated above, at 6 59 a. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) M. Franklin Smith, M. D.

4/27/1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Geneva. Ontario New York

DATE OF BURIAL 4-28 1930

20 UNDERTAKER Henry W. Jenkins Son Co.

ADDRESS Orchard McCulloh.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56595

CERTIFICATE OF DEATH

31 ✓ E 56595

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 S Milton Ave. WARD) 3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Wojcik

(a) RESIDENCE NO. 713 S Milton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unk.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Jan Wojcik

11 BIRTHPLACE OF FATHER (City or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unk.

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Poland

14 Informant Helen Hetmanska

(Address) 713 S Milton Ave

15 Filed APR 28 1930 19 CLAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26-30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1929, to April 26, 1930, that I last saw h... alive on April 26, 1930 and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Pulm. TB.

(duration) yrs. unknown ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis Janiszewski, M. D.

4/28 19 (Address) 2431 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	April 29 1930

20 UNDERTAKER F W Ozgowski ADDRESS 1930 Eastern Ave

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 56596

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4-4 E 56596

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Baltimore Gen Hosp.

CITY OF BALTIMORE: (No. Baltimore, Md ST. 14-59 WARD)

2-FULL NAME Wesley Holmes

(a) RESIDENCE NO. 2125 Division St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	c	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	55	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... General odd work

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) Anne Arundel Co
(State or country)

PARENTS

10 NAME OF FATHER Nathaniel Holmes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) A A. Co Md.

12 MAIDEN NAME OF MOTHER Eliza

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Eliza Wesley
(Address) 2125 Division St

15 Filed APR 28 1936 By HAROLD JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26 1930

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to April 26, 1930, that I last saw him alive on April 25, 1930, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4-3-30

Was there an autopsy? No

What test confirmed diagnosis? X'R

(Signed) S. A. Alessi, M. D.

(Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Auburn Cemetery

DATE OF BURIAL 2/29 1930

20 UNDERTAKER Thomas. E. Kelson

ADDRESS 1303 Presstman St

CAUSE OF DEATH must be plainly written. Avoid use of abbreviations. TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56597 3/ E 56597

E 56597

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) WARD 14-20

CITY OF BALTIMORE: (No. ..... ST.....

2-FULL NAME James Boadley

(a) RESIDENCE NO. 538 Mission Court ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Naomi Boadley

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
40	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer C40

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Boadley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Nancy Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1930, to April 25, 1930, that I last saw him alive on April 25, 1930, and that death occurred, on the date stated above, at 12.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis and

tuberculous peritonitis

(duration) indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Jas Gilmour Jr M. D.

4-25, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 4/28, 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pressman St

RECEIVED HAMPTON JONES, M. D. RMC

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56598 E 56598

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 935 N. Calvert ST. 11-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Bradenbaugh

(a) RESIDENCE NO. 935 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of John Bradenbaugh

6 DATE OF BIRTH (month, day, and year) Dec. 21 1854.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	4	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Harford Co; Md.

PARENTS

10 NAME OF FATHER Shadrach Streett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co, Maryland.

12 MAIDEN NAME OF MOTHER Rachel Ann Ensor.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Black Rock. Maryland.

14 Informant Mrs. L. H. Lamb (Address) 935 N. Calvert st

15 Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27- 1930

17 I HEREBY CERTIFY, That I attended deceased from April 18- 1930, to April 27- 1930, that I last saw h[illegible] alive on April 22- 1930, and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer.

over

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Nephrolithiasis

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy

(Signed) Chester Rikund, M. D.

4-27 1930 (Address) 2532 Edmondson ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Kenbue, Balto Co, Md — DATE OF BURIAL: April 30 1930

20 UNDERTAKER: P. Mastelline Sons — ADDRESS: White Hall Md

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 56599

E 56599

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 E. Lanvale ST., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Armstrong

(a) RESIDENCE NO. 1235 E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Lee Armstrong Sr

6 DATE OF BIRTH (month, day, and year) Sept 25 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER John B. Shaughnessy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Kate Minnick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Wm L. Armstrong Sr.

(Address) 1235 E. Lanvale St.

15 Filed 2 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26-30

17 I HEREBY CERTIFY, That I attended deceased from 4-19-, 1930, to 4-26-, 1930, that I last saw her alive on 4-26-, 1930 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Aylett, M. D.

19 (Address) 2802 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL 4/29 1930

20 UNDERTAKER Leonard J. Ruch

ADDRESS 6405 Sefton

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56600

100-001

E 56600

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1036 Valley St Sth 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. McDonnell

(a) RESIDENCE NO. 1036 Valley st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year) Dec 29, 1929

7 AGE — Years: — Months: 4 Days: 27 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Michael J. McDonnell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Julia T. O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Michael J. McDonnell 1036 Valley St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 15, 1930, to Apr 26, 1930, that I last saw him alive on Apr 21, 1930, and that death occurred, on the date stated above, at 5-30 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) L. McCarter, M. D.

..., 19... (Address) 1114 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patrick Cemetery

DATE OF BURIAL: April 29, 30

20 UNDERTAKER: Elmer W. Conklin

ADDRESS: 924 E Eager St

TION is very important See instructions on back of certificates.

APR 28 1930 C. HAROLD JONES, M.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56601 E 56601

CERTIFICATE OF DEATH.

REGISTERED NO. 90-69

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2113 Edmondson ave St. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frederick J Josenhans

(a) RESIDENCE No. 2113 Edmondson Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Frederick Josenhan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm B Josenhan

(Address) 2113 Edmondson Ave

15 Filed ..., 19... Registrar

R 2 9 1930 H. HARRISON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 27th 1930

17 I HEREBY CERTIFY, That I attended deceased for one or more years, 19..., that I last saw him alive on Apr. 27th, 1930, and that death occurred, on the date stated above, at 11:50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic heart disease, = cardiac dilatation etc,

(duration) Several years.

CONTRIBUTORY (Secondary) X

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? General dyspnoea & heart signs.

(Signed) O. H. Hoffman M. D.

4/28 1930 (Address) 7500 Garrison Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL April 29 1930

20 UNDERTAKER J Vernon Keehner — ADDRESS 1107 Hollins

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56602

CERTIFICATE OF DEATH

REGISTERED NO. E 56602

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Body found floating in the water at Booze Ship Yard, Key Highway & Light Street.

City of Baltimore: (No. Booze Ship Yard, Key Highway St., 27-33 Ward)

2-FULL NAME Isaiah Taylor.(C)

(a) RESIDENCE NO. 708 S. Charles St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	45	----	------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Hester Emerson.(C)
(Address) 700 S. Charles St.

15 Filed ....., 19 ..... H. Hanson Jones, M. D. Registrar

PR 26 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Found April 21, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Probably accidental.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto C. Reinhardt, M. D.

4/28, 1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion C	April 28 1930
20 UNDERTAKER	ADDRESS
J. E. Brown & Son	1124 Mount

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

Charles Sellman

E 56603

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56603

CERTIFICATE OF DEATH

49

REGISTERED NO. 20-69

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

2—FULL NAME Charles M. Sellman

(a) RESIDENCE NO. 168 S. Caboston Road WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes M. Sellman

6 DATE OF BIRTH (month, day, and year) Aug 16 - 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) B.T.O. R.R. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Sellman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Agnes M. Sellman

(Address) 168 S. Caboston Road.

15 Filed APR 26 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22nd 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1930, to April 22nd, 1930,

that I last saw h... alive on April 22nd, 1930

and that death occurred, on the date stated above, at 7.00 p. m.

The CAUSE OF DEATH* was as follows:

Epithelioma of mediastinum

(duration) yrs. 4 mos. 1½ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Louis J. Gundry, M. D.

4-23, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Apr. 29 1930

20 UNDERTAKER George L. Schwartz — ADDRESS 410 Fulton Ave.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56604

CERTIFICATE OF DEATH

E 56604

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE, (No. Sydenham Hospital ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Kraft

(a) RESIDENCE NO. 1933 Ridgehill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 19, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Albert Kraft

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Meyer

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Albert Kraft

(Address) 1933 Ridgehill Ave

15 Filed APR 28 1930 CLAYTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to April 28, 1930, that I last saw h.. alive on April 28, 1930 and that death occurred, on the date stated above, at 1 30 a m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Cellulitis of Neck

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Incision of Cellulitis Date of April 21, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron S. Gill, M. D.

4/28, 1930 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Retreat — DATE OF BURIAL April 30 1930

20 UNDERTAKER Sarah Ryer — ADDRESS 1400 W Baltimore

Spec.—8-16-29—L. F. S.—100 Bks.

E 35619 E 56605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 56605

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 15-56 WARD

2—FULL NAME William Cox

(a) RESIDENCE NO. 4602 Daytona Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm G Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Martha Connal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27-1930

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1930, to April 27, 1930, that I last saw him alive on April 27, 1930 and that death occurred, on the date stated above, at 935 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, hypertension

Chronic nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericarditis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Post-mortem findings

(Signed) James Bordley Jr, M. D.

4-28, 1930 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL April 30 1930

20 UNDERTAKER Veale Dyer

ADDRESS

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

✓ E 56606

E 56606 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 E. 41st ST. (WARD) 7-11

2-FULL NAME Margaret A. Paff

(a) RESIDENCE NO. 602 E. 41st ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Louis C. Paff

6 DATE OF BIRTH (month, day, and year) Apr. 29 1854

7 AGE: Years 75; Months 11; Days 29; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER John Schaunessy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Ann McHeine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ire.

14 Informant (Address): Mary E. Paff 602 E. 41st

15 Filed APR 28 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25/30

17 I HEREBY CERTIFY, That I attended deceased from 4/15/30, 19..., to 4/25/30, 19..., that I last saw h[illegible] alive on 4/25/30, 19..., and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) H. W. Gadden, M. D.

4/28/30 19... (Address) 321 E 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Apr 29 1930

20 UNDERTAKER: John A. Moran — ADDRESS: 3000 E. Balto St

FROM Very Important. See Instructions on Back of Certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56607

CERTIFICATE OF DEATH.

100-001

E 56607

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST. 11-56 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mollie Harrop

(a) RESIDENCE NO. 4600 Roland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE: Years 55 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas Harrop

11 BIRTHPLACE OF FATHER (city or town) (State or country) Manchester England

12 MAIDEN NAME OF MOTHER Susan Farley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs H Hall

(Address) 4600 Roland Ave

15 Filed 6-19-1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25-1930

17 I HEREBY CERTIFY, That I attended deceased from 4-18, 1930, to 4-25, 1930

that I last saw her alive on 4-25, 1930,

and that death occurred, on the date stated above, at 10:00 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner M.D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery DATE OF BURIAL April 29 1930

20 UNDERTAKER Mary M Woodcock ADDRESS 30 E 32

CAUSE OF DEATH is plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56608

CERTIFICATE OF DEATH

101-021

E 56608

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1031 N. Stricker St. 16-27 Ward)

2-FULL NAME Leonard Jennings

(a) RESIDENCE NO. 1031 N. Stricker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17 1911

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	10	9	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER William Jennings

11 BIRTHPLACE OF FATHER (city or town) [illegible]
(State or country)

12 MAIDEN NAME OF MOTHER Mary Stewart

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant [illegible]
(Address) [illegible]

15 Filed ..., 19... [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 29 1920

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, au
find that said deceased came to ... death
topsy or inquiry)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Apr 30	1920
20 UNDERTAKER	ADDRESS
Joseph A. Swetz & Son	Mount Auburn

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 56609

E 56609

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 Mulberry ST. M-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mable Elizabeth Wilson

(a) RESIDENCE NO. 625 W Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: 7

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): Nov. 22. 1918

7 AGE: Years 11 | Months 5 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Portsmouth Va

PARENTS

10 NAME OF FATHER: Libbrun Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mable Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mable Wilson

(Address) 762 W Mulberry st

15 Filed 4-28 1930 C. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1931

17 I HEREBY CERTIFY, That I attended deceased from March 26. 1931. to April 27. 1931.

that I last saw h[illegible] alive on April 26. 1931

and that death occurred, on the date stated above, at 1200 p m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the face, neck + lungs

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) [illegible], M. D.

. 19 (Address) 163 Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary April 30 1931

DATE OF BURIAL

20 UNDERTAKER: Joseph A Lively

ADDRESS 4029 Main st

Spec.—8-16-29—L. F. S.—100 Bks.

2 35819
2 E 56610

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 56610

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irving H. Walker

(a) RESIDENCE NO. 1001 St Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan-3-1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Radio Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER J McGill Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Bessie Marston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April-26-1930

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1930, to April 26, 1930, that I last saw him alive on April 26, 1930 and that death occurred, on the date stated above, at 4^00 A m.

The CAUSE OF DEATH* was as follows:

Acute Agatis Acute exhaustion
fatal Acute exhaustion

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Cumberland Md.

Did an operation precede death? yes Date of 4/9/30

Was there an autopsy? yes

What test confirmed diagnosis? Myocardial Weakness

(Signed) H. C. Smith, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Apr 29 19 30.
20 UNDERTAKER	ADDRESS
Stewart & Co	Balto.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56611

E 56611

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2123 St. Paul ST., (12th WARD)

2—FULL NAME Robert Wier

(a) RESIDENCE NO. 2123 St. Paul ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. — mos. — ds. How long in U. S., if foreign birth 85 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Frances Wier

6 DATE OF BIRTH (month, day, and year) June 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about 85	—	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods

(c) Name of employer J. H. Woods Son

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Robt Wier

11 BIRTHPLACE OF FATHER (city or town) Tonegal

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Eliza Johnson

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Maryland

14 Informant Mrs Edith W. Stone (Daughter)

(Address) 2123 St. Paul St.

15 Filed ..., 19 ... Registrar

28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26-1930

17 I HEREBY CERTIFY, That I attended deceased from December 21, 1929, to April 27th, 1930, that I last saw h... alive on April 26th, 1930 and that death occurred, on the date stated above, at 10.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis

Unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) ... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Helen S. Owen, M. D.

, 19 (Address) 2827 Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Apr 29 19 30
20 UNDERTAKER Stewart & Co	ADDRESS Balto.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56612

CERTIFICATE OF DEATH

47 E 56612

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 Bolton ST. 14-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Alice Smith

(a) RESIDENCE NO. 1702 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 85 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) About 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About 85		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Alexandria

(State or country) Virginia

PARENTS

10 NAME OF FATHER Thos. W. Smith

11 BIRTHPLACE OF FATHER (city or town) Alexandria

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ellen Rattles

13 BIRTHPLACE OF MOTHER (city or town) Alexandria

(State or country) Virginia

14 Informant John F. Davis - Nephew

(Address) Union Trust Bldg

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 - 1930

17 I HEREBY CERTIFY, That I attended deceased from January, 1930, to April 27, 1930, that I last saw her alive on April 27, 1930 and that death occurred, on the date stated above, at 11:35 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma breast -

(duration) Several yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 1921 -

Was there an autopsy? no -

What test confirmed diagnosis?

(Signed) Chas W Lavard, M. D.

April 28, 1930 (Address) 327 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Alexandria Va. DATE OF BURIAL 4/30/29 19 30

20 UNDERTAKER Stewart & Howard & Dello ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56613 ✓ X 44 E 56613

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 90 Ainsworth St. 10-14 WARD)

2—FULL NAME Sr. M. Emmerana Kautzmann

(a) RESIDENCE NO. Motherhouse of Notre Dame ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 8 mos. ..... ds. How long in U. S., If foreign birth? 49 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Religious 065

(c) Name of employer School Sisters of Notre Dame

9 BIRTHPLACE (city or town) France
(State or country)

PARENTS

10 NAME OF FATHER James Kautzmann

11 BIRTHPLACE OF FATHER (city or town) France
(State or country)

12 MAIDEN NAME OF MOTHER Marianne Kelber

13 BIRTHPLACE OF MOTHER (city or town) France
(State or country)

14 Informant Sister of Notre Dame
(Address)

15 Filed ..... 19 ..... Registrar,

C. HAMPSON JONES, M. D.

2 8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1930

17

I HEREBY CERTIFY, That I attended deceased from August 2, 1929, to April 27, 1930,

that I last saw h.... alive on April 27, 1930

and that death occurred, on the date stated above, at 2.50 P. M. m.

The CAUSE OF DEATH* was as follows:

Cyrcinoma Stomach
Greater Curvature Stomach
Inoperable (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? usual ones

(Signed) F. J. Kirby, M. D.

4/28, 1930 (Address) 110 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loretto Cliff Md	3/29/ 1930
20 UNDERTAKER Frank A. Fink	ADDRESS 915 W. Lanvale

Spec.—1-30—M. & T.—250 Bks.

E 56614 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56614

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMCRE: (No. Mercy Hospital St. 14-20 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Margaret Bryan Kearns

(a) RESIDENCE NO. 1611 Park Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 12, 1909

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
12 yrs.	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): York Pa.

PARENTS

10 NAME OF FATHER: Mr. John Kearns

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Margaret Talbot

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: John Kearns
(Address) 303 W. Mt St York Pa

15 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27-1930

17 I HEREBY CERTIFY, That I attended deceased from 4/10, 1930, to 4/27, 1930, that I last saw h[illegible] alive on 4/27, 1930, and that death occurred, on the date stated above, at 10:15 P.m.

The CAUSE OF DEATH* was as follows: Pernicious Vomiting

10 mos. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lawrence Kendall, M. D.

, 19 (Address) 300 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: York Pennsylvania — DATE OF BURIAL: 4/28 1930

20 UNDERTAKER: William Cook — ADDRESS: 217 St Paul St

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56615

E 56615

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Pier 6 Pratt St. St., 4-6 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME W. H. Clark

(a) RESIDENCE NO. Knoxville Tenn. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M.	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
50?				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 0.50
(c) Name of employer

9 BIRTHPLACE (city or town) Knoxville
(State or country) Tenn.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Charles Russell
(Address) 848 E Fait St

15 Filed ..., 19.. C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Whitley Cunn, M. D.

4.23 1930 (Address) 1654 Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	APR 28 1930
20 UNDERTAKER	ADDRESS
Commissioner Health.	

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

4-28-1930 4-28-1930 MORGUE;

Per Wm. E. WOODALL

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56616

CERTIFICATE OF DEATH

129 E 56616

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. South Baltimore General Hospital ST. WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas B. Hill

(a) RESIDENCE NO. 1226 Argyle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Josephine Hill

6 DATE OF BIRTH (month, day, and year) Unknown 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
65				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS
10 NAME OF FATHER Martin Hill
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Fannie Hill
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Josephine Hill
(Address) 1226 Argyle ave

15 Filed ____, 19____ Registrar

C. RAWSON JONES, M. D.
APR 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26-30

17
I HEREBY CERTIFY, That I attended deceased from 4-24, 1930, to 4-26, 1930
that I last saw him alive on 4-26, 1930
and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardio-Renal Vascular Disease

Cerebral Hemorrhage (duration) yrs. mos. 4 wks.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical signs

(Signed) Joseph Earl Carter M. D.

, 19 (Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 3-29 1930

20 UNDERTAKER John H. Scarborough

ADDRESS 1627 Edmondson Ave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56617

E 56617

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3507 N. Charles St. 12-49 WARD)

2-FULL NAME Marietta Leftwich Young

(a) RESIDENCE NO. 3507 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed~~, or divorced ~~HUSBAND of~~ (or) WIFE of E. B. Young

6 DATE OF BIRTH (month, day, and year) Nov 3rd 1872

7 AGE: Years 57 Months 5 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Espanola Cuba

PARENTS

10 NAME OF FATHER Alexander Hamilton Leftwich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lynchburg Va

12 MAIDEN NAME OF MOTHER Annie B. Slater

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Espanola Cuba

14 Informant E. B. Young Jr.

(Address) 3507 N. Charles St

Filed APR 28 1930, 19.. C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27th 1930

17

I HEREBY CERTIFY, That I attended deceased from ——, 1922, to April 27, 1930,

that I last saw h. alive on April 27, 1930,

and that death occurred, on the date stated above, at 10:50 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. B. Hubert, M. D.

(Address) 1403 Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: April 29, 30

UNDERTAKER: Percy Watkins & Sons Co

ADDRESS: Eutaw & Fayette Sts

Spec.—1-30—M. & T.—250 Bks.

E 56618 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56618

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore City Hospitals (T.B. 3-4 WARD)

CITY OF BALTIMORE: (NO. ..... ST. .....)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie Lee Moore

(a) RESIDENCE NO. 17 S. Bond st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed ..... C. HAMPSON JONES, M. D. Registrar
APR 8 1930 Ret

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1930 to April 25, 1930.

that I last saw her alive on April 25, 1930,

and that death occurred, on the date stated above, at 11.15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) indefinite ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Jas. Johnson M.D.

4-29, 30 (address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cemetery	4/29/30
UNDERTAKER Robert E. Williams	ADDRESS 1515 W. Lafayette Ave

FROM A very important See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56619

101-001

CERTIFICATE OF DEATH

E 56619

REGISTERED NO. 90-27

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 W. Lexington ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles McLaughlin, Sr.

(a) RESIDENCE NO. 1804 W. Lexington St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 9 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Ella McLaughlin,

6 DATE OF BIRTH (month, day, and year) July 13, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Leonard McLaughlin,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Charles McLaughlin

(Address) 1804 W. Lexington St

15 Filed APR 28 1930 19 C. Henderson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 10, 1930, to Apr 26, 1930, that I last saw h[illegible] alive on Apr 26, 1930 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Rosser, M. D.

4-28-30 (Address) 1939 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL APR 29 1930

20 UNDERTAKER Geo W Little

ADDRESS 2700 [illegible] ONDON AVE.

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56620

E 335486 56620

CERTIFICATE OF DEATH

132

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vincent Tasca

(a) RESIDENCE NO. 601 N. Rose ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Domenico Tasca

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Adelina (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

11 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 4-28-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27-1930

17 I HEREBY CERTIFY, That I attended deceased from March 29 1930 to April 27 1930

that I last saw h. (m.) alive on April 27 1930

and that death occurred, on the date stated above, at 4^00 A.m.

The CAUSE OF DEATH* was as follows: Aortic Insufficiency. Operation: Ligation of Aorta - with stump. Secondary hemorrhage. Toxic myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) ? General Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of April 12, 1930

Was there an autopsy? No

What test confirmed diagnosis? X-ray, Operation

(Signed) H. Smith, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL April 30 1930

20 UNDERTAKER John Allrich

ADDRESS 200 N. Eden

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56621

45 E 56621

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 708 S Bond St., 3-4 Ward)

2-FULL NAME Victor Tanner

(a) RESIDENCE NO. 708 S Bond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept 29-1888

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
41 42	6	23 29		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) 015
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Finland

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Finland

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Finland

14 Informant Mrs W. B. Stonnell
(Address) 1908 N Collington

15 Filed ....., 19.... C. HANSON JONES II Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Myocarditis 2 Hemorrhage Lung

(Duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) C Hanson

(duration) yrs. mos. 1 da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of 4/26/30

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J C Baker, M. D.

, 19 (Address) 3 B Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem

DATE OF BURIAL Apr 29 1930

20 UNDERTAKER Lorsa Miller

ADDRESS 208 Ellam

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Mourning of Murgatroyd

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56622

CERTIFICATE OF DEATH

E 56622

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 449 Whitridge Ave St. 12-50 Ward)

2-FULL NAME Ernestine J Walters

(a) RESIDENCE NO. 449 Whitridge Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single~~, Married, ~~Widowed or Divorced, (write the word)~~
Female	W	Married

5a If married, widowed or divorced ~~HUSBAND of~~ (or) WIFE of John C Walters

6 DATE OF BIRTH (month, day and year) Dec 13 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	53	6	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) New York

PARENTS

10 NAME OF FATHER Gustav Krause

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Krause

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New York

14 Informant John C Walters
(Address) 449 Whitridge Ave

15 Filed ..... 19.... Registrar

R 8 1930 C. HARRISON JONES, M. D.

Fee 10 cts

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26-30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH was as follows:

Tabular Disease
F J Heart

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Bonnell, M. D.

4/28 1930 (Address) 763 Robinson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Hebron, Brooklyn Md	4 30 1930
20 UNDERTAKER	ADDRESS
W Cook	217 St. Paul St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56623

CERTIFICATE OF DEATH

199

E 56623

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 114 Hospitals St., 1-V Ward)

2-FULL NAME Louise Morant

(a) RESIDENCE NO. 612 S. Caer Av St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan-1-1856

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	74	4	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Nurse
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Geo Morant

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Donohue
(Address) 612 S Caer Av

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck by Hit + Run driver (By an automobile) Hom

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Trans Stroke

(duration) yrs. mos. ds.

18 Where was disease contracted? Caer Av If not at place of death? City Hosp

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) H. H. Frame, M. D.

4/27/1930 (Address) 3939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	4-29 1930

20 UNDERTAKER W. Cook ADDRESS 1217 N Paul St

RKH

Spec.—1-30—M. & T.—250 Bks

Dr Leary - 910 Lombard St. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE — E 56624

E 56624

CERTIFICATE OF DEATH.

122 - 802

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 502 S. Gilmore ST. 14-28 (WARD)

2-FULL NAME Benjamin Franklin Brogan

(a) RESIDENCE NO. 502 S. Gilmore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie L Brogan

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cty Messenger Cty

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (City or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Edyar Hostnagle (Address) 502 S. Gilmore St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28th 1930

17 I HEREBY CERTIFY, That I attended deceased from 11/23/, 1929, to 4/28/30, 19 ,

that I last saw h— alive on 4/28/30, 19 ,

and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Liver

Ch. Diffuse Nephritis

(duration) unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual constituents

(Signed) Bernard J. Feeney, M. D.

4/30/, 1930 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon P.K

DATE OF BURIAL 4-30-30

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

TION IS VERY Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001 ✓

E 56625

CERTIFICATE OF DEATH

E 56625

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hosp 17-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles J. Shields

(a) RESIDENCE NO. 3032 Greenmount Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE) of Mrs. Chas. J. Shields

6 DATE OF BIRTH (month, day, and year) Nov. 15, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) 004

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Missouri

PARENTS

10 NAME OF FATHER Edmund J. Shields

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ohio

12 MAIDEN NAME OF MOTHER Alice Wanken

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. Chas. Shields

(Address) 3032 Greenmount Ave

15 Filed ....., 19 ..... Registrar

R 2 8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1930, to April 28, 1930

that I last saw h... alive on April 28, 1930 (Daylight)

and that death occurred, on the date stated above, at 7:15 A.m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric ulcer

(duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted if not at place of death? 3032 Greenmount Ave.

Did an operation precede death? Yes Date of 4/23/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Albert R. Wilkerson, M. D.

, 19 (Address) Union Mem. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

DATE OF BURIAL 4/30 1930

20 UNDERTAKER

ADDRESS

Wm. Cook 1217 St. Paul St

important. See instructions on back of certificate.

Spec.—1-31—M. & T.—250 Blks

Dr Frey Practitioner + Fenna ✓

E 56626

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 56626

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1801 Linden Ave (Hosp.) H-20 (Ward)

2-FULL NAME Martha C. Sparrow

(a) RESIDENCE NO. 1801 Linden Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Henry C. 1838

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
92			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Devine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Cane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Frank A. Sparrow
(Address) 1801 Linden Ave

Filed 2-8-1930, 19.....

nhh Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1930, to Apr 27, 1930,

that I last saw her alive on Apr 27, 1930,

and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Frey, M. D.

7-28, 1930 (Address) 1928 Fenna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	4-29-30
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

May 21 1892

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56627-1

CERTIFICATE OF DEATH

188-203

E 56627

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St Joseph's Hosp St 15-64 Ward)

2-FULL NAME Frank W Nichols

(a) RESIDENCE NO. 3915 Liberty Heights St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Nichols

6 DATE OF BIRTH (month, day, and year) May 20 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
59	58	11	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tobacco
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co Md
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Scotland
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Scotland

14 Informant Harry Glaser
(Address) 3236 Ellerslie Ave

15 Filed ....., 19..... ARH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck by auto while crossing road
a
(duration) hr yrs. mos. ds.
CONTRIBUTORY Fract Skull
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Putty Hill & Belair Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J Strauss, M. D.

4 28 1930 (Address) 3989 W Belvedere

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	4-29-1930

20 UNDERTAKER Wm Cook ADDRESS 1217 N Paul St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 56628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 56628

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 325 Ruggold St. 21-29 Ward)

2-FULL NAME Charles C. Sewell

(a) RESIDENCE NO. 325 Ruggold St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nettie Sewell

6 DATE OF BIRTH (month, day, and year) May 25-1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	47	11	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph Sewell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Harriett Ennis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Nettie Sewell
(Address) 627 Dolphin St

15 APR 29 1930 19 C. HAMPSON GIBSON, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage
Probably due to Pulmonary Tuberculosis (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)
(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Peltier M. D.

4/28, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Apr 29, 1930

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Druid Hill Ave

2 OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56629

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 56629

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 151 W. Hamburg ST. 23-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carroll Wiggins

(a) RESIDENCE NO. 151 W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4/25/1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. City (State or country)

PARENTS

10 NAME OF FATHER Jesse Wiggins

11 BIRTHPLACE OF FATHER (city or town) Norfolk (State or country) Virginia

12 MAIDEN NAME OF MOTHER Delsy Lee

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Edith Lee

(Address) 151 W. Hamburg St.

15 Filed APR 29 1930, 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/28/1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 25, 19 30, to Apr 28, 19 30, that I last saw h[illegible] alive on Apr 28, 19 30 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Premature Delivery (8 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D H Carroll, M. D.

4/28, 1930 (Address) 830 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Apr 29, 19 30

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Druid Hill

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56630

CERTIFICATE OF DEATH

E 56630

1—PLACE OF DEATH Ten Hills REGISTERED NO.

CITY OF BALTIMORE: (No. 4907 Edmondson Ave. ST. 28-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Milton J. Byrd

(a) RESIDENCE NO. 4907 Edmondson Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Belle S. Byrd

6 DATE OF BIRTH (month, day, and year) Oct. 27, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm. S. Byrd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary J. Broughton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Belle S. Byrd
(Address) 4907 Edmondson Ave.

15 4-29-1930 C. HARRY JONES, M. D.
4-29-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to April 26, 1930, that I last saw him alive on April 26, 1930 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Haemaplegia Right

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Arthritis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emma C. Clarke, M. D.

4, 28, 1930 (Address) La Fetra Apts. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery Co.	April 28 1930
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 56631

CERTIFICATE OF DEATH.

E 56631
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Riggs Av St. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorraine Corbin

(a) RESIDENCE. No. 1604 Riggs Av St., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. X mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 3-1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER William Corbin
11 BIRTHPLACE OF FATHER (city or town) Mutatone
(State or country) Va
12 MAIDEN NAME OF MOTHER Lula Campbell
13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mother
(Address) 1604 Riggs Av

15 Filed APR 29 1930 19 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1930

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1930, to April 26, 1930, that I last saw h er alive on April 26, 1930, and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Breath & Mirror
(Signed) Joseph Sieden, M. D.
(Address) 2348 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Apr 29 1930

20 UNDERTAKER: Sam'l H Chase Son — ADDRESS: 1400 Mosher

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

Insley.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56632

CERTIFICATE OF DEATH.

101-001

E 56632

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.) ST. 1-3 WARD)

2-FULL NAME John F. Insley

(a) RESIDENCE NO. 519 S. Bradford ST., 1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Carrie Insley

6 DATE OF BIRTH (month, day, and year) Nov. 23 1881

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 0.30

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Insley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records.
(Address)

15 Filed APR 29 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27-30

17 I HEREBY CERTIFY, That I attended deceased from 4-26, 1930, to 4-27, 1930, that I last saw him alive on 4-27, 1930, and that death occurred, on the date stated above, at 11 42 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Emphysema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyh, M. D.

4/27, 1930 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery.	April 30 1930
20 UNDERTAKER	ADDRESS
Lilly & Zeiler Inc.	403 S. Wolfe St

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56633

CERTIFICATE OF DEATH

74-001

E 56633

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 1-3 Ward)

2-FULL NAME Charles H. Klehm

(a) RESIDENCE NO. 301 S. Chester St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie C. Klehm

6 DATE OF BIRTH (month, day, and year) Apr 4/1869

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	61	0	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Painter
(b) General nature of industry, business, or establishment in which employed (or employer) & Decorator
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Adam Klehm

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Wilmington, Del.

12 MAIDEN NAME OF MOTHER Elizabeth Steel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Annie C. Klehm
(Address) 301 S. Chester St

15 Filed ..... 19.... Registrar

APR 29 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27/1930

17 I HEREBY CERTIFY, That I took charge of the remains deacribed above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apoplexy)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) [signature] M. D.

4/29/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Apr 30th 1930
20 UNDERTAKER	ADDRESS
Lilly & Zeiler Inc	400 S. Mont. St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Gittings
101-001

E 56634

CERTIFICATE OF DEATH.

E 56634

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3240 Barkley St. 17-50 Ward)

2-FULL NAME Laurence Gittings

(a) RESIDENCE NO. 3240 Barkley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 50 Months Days IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stoker

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md.

PARENTS

10 NAME OF FATHER: James Gittings

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Charles Hellings

(Address) 3240 Barkley St

15 Filed ... 19 ... C. HAMILTON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) J. Lut Mowbray M. D. (Coroner)

4/28, 1930 (Address) 1632 Boland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Crem. Date of Burial: 4-30 1930

20 UNDERTAKER: Bynon Wright ADDRESS 1218 McElderry St

Oil of death in pain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56635 CERTIFICATE OF DEATH E 56635

161-001

REGISTERED NO.

1—PLACE OF DEATH South Balto. Gen. Hosp. 12-19 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. (WARD)

2—FULL NAME Baby Boy Barr

(a) RESIDENCE NO. 416 E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-4-30.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Robert Barr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Jean Norenius

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant

(Address)

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5/30

17 I HEREBY CERTIFY, That I attended deceased from 3/4/30, 19..., to 3/5/30, 19..., that I last saw h. (he) alive on 3/5/30, 19..., and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Immature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Francis V. Tullis, M. D.

, 19 (Address) S.B. Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL S. B. Balto Gen. Hosp

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER

Important. See instructions on back of certificate.

MAR 29 1930 HAMILTON JONES, M. D. Registrar

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56636

CERTIFICATE OF DEATH

100-001

E 56636

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 746 Pierce St., 17-16 Ward)

2-FULL NAME Emma Grant

(a) RESIDENCE NO. 746 Pierce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Alabama

PARENTS

10 NAME OF FATHER John H. Arron

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ala.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Wilton Wilborn
(Address) 746 Pierce St

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Entero-colitis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Augus Feller, M. D.

4/28 1930 (Address) 29 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Carter Lane

20 UNDERTAKER Daniel Easton

DATE OF BURIAL 4-29 1930

ADDRESS 916 Ea ave

Spec.—1-30—M. & T.—250 Blks.

E 56637 E 56637

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 1 ✓

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 15-21 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Price

(a) RESIDENCE NO. 1615 W. Presstman st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Bob Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Lulu Bruce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Records (Address)

15 Filed APR 29 1930 H. R. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1929, to April 27, 1930, that I last saw her alive on April 27, 1930, and that death occurred, on the date stated above, at 11.15 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Jas. Shumer Jr, M. D.

4-27 1930 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem

DATE OF BURIAL 4-29 1930

20 UNDERTAKER Dennis Eastern

ADDRESS 916 Eager

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 56638 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56638

CERTIFICATE OF DEATH.

74-001

13-52

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4104 Roland Ave. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Anna B. Strasbaugh

(a) RESIDENCE No. 4104 Roland Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry P. Strasbaugh

6 DATE OF BIRTH (month, day, and year) Oct. 14, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. H. Bayless

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER Annie P. Silver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co., Md.

14 Informant John Z. Bayless (Address) Montrose Road, Ruxton, Md.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov., 1927, to April 27, 1930, that I last saw h[illegible] alive on April 27, 1930 and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

General Arterio Sclerosis

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Hemorrhage into 4th Ventricle

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual Symptoms

(Signed) Standish McAlpin, M. D.

, 19 (Address) 1609 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harmony, Harford Co., Md.	April 30, 30
20 UNDERTAKER John O. Mitchell & Sons	ADDRESS 1900 Eutaw Pl.

Mabel B. Mitchell

4-29-1930 [illegible] JONES, M. D.

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

233273 E 56639

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56639

CERTIFICATE OF DEATH

49

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2—FULL NAME Alfred Ernest Foley

(a) RESIDENCE NO. Chicago Ill ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dagmar Foley

6 DATE OF BIRTH (month, day, and year): Aug-12-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sales Manager

(b) General nature of industry, business, or establishment in which employed (or employer): Coleman Lamp & Stove Co

(c) Name of employer: Mr. Parr

9 BIRTHPLACE (city or town) (State or country): Mich

PARENTS

10 NAME OF FATHER: Cornelius Foley

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER: Cora Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ind.

14 Informant: Records

(Address) ?

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1930, to April 29, 1930, that I last saw h[im] alive on April, 1930 and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Carcinoma ? of Bladder

Urinary (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cystoscopy

(Signed) A. Smith, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chicago Ill	Apl 29 1930
20 UNDERTAKER: Wm Stickney Sons	ADDRESS: North Ave

C. HANSON JONES

Spec.—1-30—M. & T.—250 Bks.

E 56640

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56640

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1625 Hilton St. 16-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Herman Schoenjahn

(a) RESIDENCE NO. 1625 Hilton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eureline E Schoenjahn

6 DATE OF BIRTH (month, day, and year) Aug. 18, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dry Cleaning Business

(b) General nature of Industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) N. Y City (State or country)

PARENTS

10 NAME OF FATHER Herman Schoenjahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lulu Weber

13 BIRTHPLACE OF MOTHER (city or town) St. Louis (State or country) Mo.

14 Informant Miss Ruth Schoenjahn (Address) 1625 N. Hilton St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26, 1930

17

I HEREBY CERTIFY, That I attended deceased from Oct. 18 - 1928, to Apr. 26 1930,

that I last saw him alive on Apr. 26th 1930,

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis with Chronic Interstitial Nephritis

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isaac Hedickson, M. D.

Apr. 28 1930 (Address) 3655 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Apr. 29 1930
20 UNDERTAKER Wm J Tucker & Sons	ADDRESS No Pa Ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56641

E 56641

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1187 N. Pafkelton ST. 18th WARD)

2-FULL NAME Georg Jr Sperlein

(a) RESIDENCE No. 1187 N Pafkelton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? 80 yrs. mos. ds.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Sperlein

6 DATE OF BIRTH (month, day, and year) May 26 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	96	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fronda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Trutmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fran Sperlein
(Address) 1187 N Pafkelton St

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27/30

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1930, to April 27, 1930.

that I last saw her alive on April 27, 1930.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Old age. Arter Sclerosis
Pulmonar heart disease

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) old age

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. K. Gonnach, M. D.

(Address) 1178 N. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 5-1-30

20 UNDERTAKER G G Ruch — ADDRESS 640 Defton

ATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56642

E 56642

CERTIFICATE OF DEATH.

REGISTERED NO. 118-81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. Gen. Hosp. ST. 22-64 WARD

2-FULL NAME Stephen L. Le Compte

(a) RESIDENCE NO. 5300 Fern Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Le Compete

6 DATE OF BIRTH (month, day, and year) Sept. 26 1869

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	60	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier

(b) General nature of industry, business, or establishment in which employed (or employer) W. J. VanHorn Coal Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James L. Le Compete

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Vandegrift

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record (Address)

15 Filed 2 9 1930 19 RPM Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1930

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1930, to April 28, 1930, that I last saw him alive on April 28, 1930, and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH* was as follows:

Bilateral herniaplasty (inguinal)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia, Cardiac, (duration) 5 days yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4-8-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

4/28/30 (Signed) Jno. A. Compton M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.

DATE OF BURIAL 4/30 1930

20 UNDERTAKER Harry A. Mitzka

ADDRESS 4101 Edmondson Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56643

CERTIFICATE OF DEATH

100-001

E 56643

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 16-76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME [redacted] John Owens

(a) RESIDENCE NO. 1110 W Lexington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alberta Owens

6 DATE OF BIRTH (month, day, and year) ? 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O+O

(c) Name of employer [redacted] Charlotte

9 BIRTHPLACE (city or town) [redacted] (State or country) N.C.

PARENTS

10 NAME OF FATHER John Owens

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) N C

12 MAIDEN NAME OF MOTHER Unknown

12 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Alberta Hall (Friend)

(Address) 1110 W Lexington St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28-30

17

I HEREBY CERTIFY, That I attended deceased from April 12, 1930, to April 28, 1930, that I last saw him alive on April 28, 1930 and that death occurred, on the date stated above, at 1 10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ... yrs. about 16 mos. ... ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) about yrs. 1/2 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chester S. C.

DATE OF BURIAL 4/30/1930

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1631 Druid Hill

Spec.—8-16-29—L. F. S.—100 Bks.

E 56644

E 56644 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST. 2748 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Mitchell

(a) RESIDENCE NO. 409 Twenty Ave ST., WARD N. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

Important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widowed

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edmund Mitchell

6 DATE OF BIRTH (month, day, and year) Feb 27, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fayetteville
(State or country) N.C

PARENTS

10 NAME OF FATHER Robert Maynor

11 BIRTHPLACE OF FATHER (city or town) Fayetteville
(State or country) N.C

12 MAIDEN NAME OF MOTHER Mary Daughtery

13 BIRTHPLACE OF MOTHER (city or town) Fayetteville
(State or country) N.C

14 Informant Gladys Mitchell
(Address) 409 Twenty Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27-30

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1930, to April 27, 1930, that I last saw h alive on April 27, 1930 and that death occurred, on the date stated above, at 5 00 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Uncomplicated)

Fibrinous Pleurisy

(duration) yrs about mos 1 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) Conrad M St Clair M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dunn - N. C.

DATE OF BURIAL 4/29/1930

20 UNDERTAKER Mrs. Geo F. Holland

ADDRESS 1631 Druid Hill Ave.

Spec.—1-30—M. & T.—250 Bks.

E 56645 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56645

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. Sewer Road Near North Point Road

REGISTERED NO. 36-27 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franz Greska.

(a) RESIDENCE No. Balto. Sewer Road Near North Point Road.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of The Late Barbera Greska.

6 DATE OF BIRTH (month, day, and year) Jan. 21 St. 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired M

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Slavia.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) Slavia. (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Slavia (State or country)

14 Informant Kunigund Sauer (Address) Sewer Road & North Point Road

15 Filed APR 29 1930 C. H. Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 27 / 30

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1930, to April 27, 1930, that I last saw him alive on April 27, 1930, and that death occurred, on the date stated above, at 6/55 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. F. Athey M. D.

April 29, 1930 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Apr. 30/30
20 UNDERTAKER	ADDRESS
D. Lilly & Zeiler Inc.	403 S. Wolfe.

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 56646

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56646

CERTIFICATE OF DEATH.

REGISTERED NO. 88

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 S. Clinton St. 76-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wallburga Burkart

(a) RESIDENCE NO. 1007 S. Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Burkart

6 DATE OF BIRTH (month, day, and year) Sept. 16-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mid-wife 86

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Streilig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant August Burkart

(Address) 1007 S. Clinton St. M. D.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to April 26, 1930, that I last saw her alive on April 25, 1930, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Gradual yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B. Tilton, M. D.

4/28, 1930 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schmaltz's cemetery

DATE OF BURIAL May 1 1930

20 UNDERTAKER George V. Zirkle

ADDRESS 1737 E. Eager St

TION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Rls.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1930 B 8

90 ✓ E 56647

E 56647

CERTIFICATE OF DEATH

REGISTERED NO. E 56647

1-PLACE OF DEATH

City of BALTIMORE: (No. 2001 N. Hilton St. 15th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa White Saxton

(a) RESIDENCE NO. 2001 N. Hilton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Alexander H. Saxton

6 DATE OF BIRTH (month, day, and year) July 28 1842

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	87	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baeto Md

(State or country)

PARENTS

10 NAME OF FATHER Alex J. White

11 BIRTHPLACE OF FATHER (City or town) Baeto Md

(State or country)

12 MAIDEN NAME OF MOTHER Matilda Algie

13 BIRTHPLACE OF MOTHER (city or town) England

(State or country)

14 Informant Miss M. Alice Saxton

(Address) 2001 Hilton St

15 Filed APR 29 1930 C. HARRISON JONES, M. D. 16

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1930

17 I HEREBY CERTIFY, That I attended deceased from — 1926 to April 28 1930

that I last saw her alive on April 28 1930

and that death occurred, on the date stated above, at about 9 a. m.

The CAUSE OF DEATH* was as follows:

Chronic End Carditis

(Mitral regurgitation)

(duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary) Indefinite

— (duration) — yrs. — mos. da.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry W. Arthur M. D.

April 28 1930. (Address) 3708 Hillsdale Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

Date of Burial May 1st 1930

20 UNDERTAKER Lemmy H. Jenkins Co.

ADDRESS McCulloh & Orchard Sts

Per R.H.F.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 56648

HEALTH DEPAR[illegible] CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 56648

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1644 Mulliken St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Lotter

(a) RESIDENCE NO. 1644 Mulliken St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. da How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, ~~Married~~, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): April 2, 1874

7 AGE: Years 56 Months — Days 26 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of indostry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Malby

(State or country): Alabama,

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Alabama

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Alabama

14 Informant: Susie Johnson

(Address): 1644 Mulliken St

15 Filed ... 19 ... C. HAMPTON JONES, M. D. Registrar

Per ... Clk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 28 19 30

17 I HEREBY CERTIFY, That I attended deceased from April 5, 19 30 to April 28, 19 30, that I last saw h[illegible] alive on April 27, 19 30, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary): Auto Nephritis

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary Examination

(Signed) R. O. Eschliman M. D.

19 (Address) 514 S Baltimore Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — Date of Burial: May 2 1930

20 UNDERTAKER: Edward Bryon — ADDRESS 1631 Orleans St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 29 1930

Spec.—1-30—M. & T.—250 Blks.

E 56649

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56649

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 13-20 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Shacter

(a) RESIDENCE NO. 2123 Balton St ST., WARD Russia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Morris Meyer Shacter

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Morris M. Shacter (Address) 2123 Balton St

15 Filed 4-29 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/29/30

17 I HEREBY CERTIFY, That I attended deceased from 4-23, 1930, to 4-29, 1930, that I last saw her alive on 4-29, 1930, and that death occurred, on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 7 ds.?

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Exam

(Signed) L. A. Silver, M. D.

4/29, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale DATE OF BURIAL 4/29 1930

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56650

CERTIFICATE OF DEATH.

129 E 56650

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Jenkins Memorial Hospital (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claude B. Stelvison

(a) RESIDENCE NO. 1905 Harlem Ave. St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs M. E. Stelvison

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER James Stelvison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital (Address)

15 Filed ....., 19.... Registrar

R 2 9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28-1930

17 I HEREBY CERTIFY, That I attended deceased from 12-6-28 [redacted], 19[redacted], to 4-28, 1930,

that I last saw h[redacted]live on 4-28, 1930,

and that death occurred, on the date stated above, at 6:40 p.m.

The CAUSE OF DEATH* was as follows:

chronic nephritis

chronic myocarditis

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) George Brown, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 5/1/30 19

20 UNDERTAKER H C Bowling Son & Polen Pon St

ADDRESS 1136

CAUSE OF DEATH IS very important See instructions on back of certificates.

1-30—M. & T.—100 B—50L

William O'conner ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56651

E 56651

CERTIFICATE OF DEATH

167-007

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 681 W. Fayette ST. 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William O'Conner

(a) RESIDENCE NO 681 W Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 087
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant
(Address)

15 Filed ....., 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Asphyxiation by C. Illuminating Gas. Suicide

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller Coroner, M. D.

4/28. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS APR 29 1930

TION is very important See instructions on back of certificates.

Exact statement of OCCUPA-

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56652

E 56652

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 Arch ST., 425 WARD)

2-FULL NAME George Hamilton

(a) RESIDENCE NO 129 Arch ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... 0?
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

PARENTS

9 BIRTHPLACE (city or town) Unknown
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant .....
(Address)

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Zelfer, M. D.
Coroner

4/28 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
UNIVERSITY OF MARYLAND

20 UNDERTAKER
Commissioner Health

DATE OF BURIAL
..... 19

ADDRESS

APR 29 1930

C. HAMPSON JONES

Bal. Wm. E. Assn.

TION is very important See instructions on back of certificates.

...ness of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56653

CERTIFICATE OF DEATH

5 / E 56653

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3525 Roland Ave. ST., 13-57 WARD)

2—FULL NAME George R. Brittingham

(a) RESIDENCE NO. 3525 Roland Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. — mos. — da. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura V. Brittingham

6 DATE OF BIRTH (month, day, and year) April 14-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	—	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George R. Brittingham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sallie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Laura V. Brittingham

(Address) 3525 Roland Ave.

15 Filed 2 9 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28-1930.

17 I HEREBY CERTIFY, That I attended deceased from March, 1930, to April 28, 1930, that I last saw h. alive on April 28, 1930 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Coronary Thrombosis

Sudden (duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Diabetes Mellitus (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E. A. Richardson, M. D.

April 30, 1930 (Address) 117 W. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL April 30-1930.

20 UNDERTAKER Horace F. Burgee ADDRESS 3031 Falls Road

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56654

CERTIFICATE OF DEATH

31 E 56654

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2040 Eastlanda ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward J. Waters

(a) RESIDENCE NO. 2040 Eastlond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 2 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Waters

6 DATE OF BIRTH (month, day, and year) Feb 24 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Coal, Shipping

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jesse Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Felder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Agnes Waters

(Address) 2040 Eastlanda

15 Filed ... 19 ... Registrar

29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1929, to April 28 1930, that I last saw him alive on April 28 1930, and that death occurred, on the date stated above, at 9.10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis (duration) 1 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? yes (sputum examination)

(Signed) H. S. Willis, M. D.

. 19 (Address) Med. Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL May 1 1930

ADDRESS

20 UNDERTAKER Funeral Direction 1906 Eastlanda

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56656 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56655

CERTIFICATE OF DEATH.

REGISTERED NO. 10190

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. S 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mack McCoy

(a) RESIDENCE NO. 1144 McElderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 25 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Hugh McCoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Jane ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Record

(Address)

15 Filed ....., 19 .... Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26-30

17 I HEREBY CERTIFY, That I attended deceased from 3-22 4-8, 1930, to 4-26, 1930,

that I last saw him alive on 4-26, 1930,

and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Empyema right chest

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 4-8-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) L. U. Crumpton, M. D.

4-27 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

UNIVERSITY OF MARYLAND

20 UNDERTAKER

C. HAMPSON JONES M. D. Commissioner Health.

DATE OF BURIAL 19

ADDRESS

APR 29 1930

TION is very important. See instructions on back of certificates.

R 29 10190

Spec.—1-30—M. & T.—250 Bks.

E 56656

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

E 56656

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 2321 STREET) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Jackson

(a) RESIDENCE NO. 239 W. Henrietta ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Davis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68 ?			

8 OCCUPATION OF DECEASED Laborer

(a) Trade, profession or particular kind of work 0.W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Peyton Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of

(Address) B. C. H.

15 Filed ....., 19 ..... Registrar

4588

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25-30

17 I HEREBY CERTIFY, That I attended deceased from 4-14-30, 19....., to 4-25-30, 19.....,

that I last saw him alive on 4-25-30, 19.....,

and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

~~Myocarditis, Chronic Fatal~~

Hemorrhage into Cerebrum, R.

(duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Syphilis, Tertiary

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical, W.R.

(Signed) Warren H. McLean, M. D.

4-25, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

C. HAMPSON JONES, Commissioner Health.

APR 29 1930

PER WM. E. NOCDAL

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56657

E 56657

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 2711 Jefferson St.

CITY OF BALTIMORE: (No. 2711 ST. 6-10 WARD)

2-FULL NAME William Washington Horton

(a) RESIDENCE NO. 2711 Jefferson St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Emily

6 DATE OF BIRTH (month, day, and year) May 9, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Glen L. Martin Co.

9 BIRTHPLACE (city or town) (State or country) Akron, Ohio

PARENTS

10 NAME OF FATHER Benjamin Horton

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Victoria Horton

(Address) 2711 Jefferson St.

15 Filed 29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1930

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1930, to April 29, 1930, that I last saw him alive on April 28, 1930, and that death occurred, on the date stated above, at 4 09 a m.

The CAUSE OF DEATH* was as follows:

Uremia,
pulmonary oedema

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Hypertension nephritis, cardiitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) L. C. Sobilad, M. D.

4-29, 1930 (Address) 447 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cleveland Ohio

20 UNDERTAKER Hillcrest Clerk

DATE OF BURIAL 4/29 1930

ADDRESS 1217 St. Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56658

CERTIFICATE OF DEATH.

90 E 56658

1-PLACE OF DEATH West Balto Gen Hosp

CITY OF BALTIMORE: (No.) Balto. Md ST. 28-63 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Townsend

(a) RESIDENCE NO. 4910 Groveland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Clarence Townsend

6 DATE OF BIRTH (month, day, and year) March 23, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Claim Investigator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles B Townsend

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Ogburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Clarence Laurence
(Address) 4910 Groveland

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-28 —, 1930, to 4-29 —, 1930, that I last saw him alive on 4-29-30, 19..., and that death occurred, on the date stated above, at 12.20 a.m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal Disease

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of 4-28-30

Was there an autopsy? No

What test confirmed diagnosis? Blood chemistry Urine analysis

(Signed) J. J. Castagna, M. D.

, 19 (Address) N Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 5/1 1930

20 UNDERTAKER W M Cook

ADDRESS 1217 Park St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56659

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 56659

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 205 E Hoffman ST., 8-17 WARD)

2-FULL NAME Charles Edward Wentz

(a) RESIDENCE NO. 2052 E Hoffman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced, HUSBAND of ~~[illegible]~~ Ethel Bertha Leach

6 DATE OF BIRTH (month, day, and year) Dec 1, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Stevedore Co.

(c) Name of employer Balt Dry Dock Co Baltimore

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Jno S Wentz.

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Martha Wentz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Ethel Bergen.
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1929, to April 28, 1930,
that I last saw h~~e~~ alive on April 28, 1930,
and that death occurred, on the date stated above, at 5.30 m. April 29/30

The CAUSE OF DEATH* was as follows:

Aortic regurgitation
Bronchiectasis
Hypostatic pneumonia
(duration) 10 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) J. Reul MacMurray M. D.

, 19 (Address) 2147 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL 5/1 1930

20 UNDERTAKER J. M. Cook

ADDRESS 1217 Pond St

TION is very important. See instructions on back of certificates.

R. 9 1930 C. HAMPSON LEWIS, M. D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56660

CERTIFICATE OF DEATH

74-001

E 56660

1-PLACE OF DEATH Jenkins Memorial Hospital — REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1000 Eaton Ave ST., 10-14 WARD)

2-FULL NAME Margaret Frank

(a) RESIDENCE NO. 703 E. Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George G Frank

6 DATE OF BIRTH (month, day, and year) July 19, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Hugh Friel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Dillon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Jenkins Memorial Hospital 1000 Eaton Ave

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

2 9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1930, to April 29, 1930, that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 5-25 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brown M. D.

..., 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 5/1 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Fayette St

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56661

CERTIFICATE OF DEATH.

23 E 56661

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... S. 4-76 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Kelly Sullivan

(a) RESIDENCE NO. 727 W. Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of James Sullivan

6 DATE OF BIRTH (month, day, and year) Unknown 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John Schelt Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of (Address) B. C. H.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28-30

17 I HEREBY CERTIFY, That I attended deceased from 6-12-25, 19..... to 4-28-30, 19.....,

that I last saw her alive on 4-28-30, 19.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Paralysis agitans
(post-encephalitic)

(duration) 9 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home; Sudan in hospital.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam + history

(Signed) Paul Padget, M. D.

4-29, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 5/1 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 Edmondson Ave

REGISTERED

NOTICE—Your attention is called to the fact that the law requires a certificate of death to be filed with the Registrar of Vital Statistics before a burial permit can be issued. Your cooperation is necessary in order that this law may be complied with. Read carefully the instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56662 | CERTIFICATE OF DEATH | 74-001 E 56662

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3003 Westwood Ave ST. 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes Evelyn Rountree

(a) RESIDENCE NO. 3003 Westwood Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William A. Rountree

6 DATE OF BIRTH (month, day, and year) June 6-1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John P. Sewary

11 BIRTHPLACE OF FATHER (city or town) Ellicott City

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Carrie Pfeiffer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland.

14 Informant Wm A. Rountree

(Address) 3003 Westwood Ave

15 Filed 2-9-1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27-1930

17 I HEREBY CERTIFY, That I attended deceased from 4-26-, 19 30, to 4-27-, 19 30,

that I last saw her alive on 4-27-, 19 30

and that death occurred, on the date stated above, at 7:10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Signs

(Signed) Chester Ruland, M. D.

4-28, 1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lot Contracted

20 UNDERTAKER J. M. Cook

DATE OF BURIAL 4/31 19 30

ADDRESS 1219 N. Fond St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56663

CERTIFICATE OF DEATH

167 E 56663

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 818 Carroll St. 21-24 Ward)

2-FULL NAME John Sfano

(a) RESIDENCE NO. 818 Carroll St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mag A. Sfano

6 DATE OF BIRTH (month, day, and year) Jan 1 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	49	3	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Straw Hat Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER (Unknown) Sfano

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs Mag A. Sfano
(Address) 818 Carroll St

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Sue death on the day stated above.
The CAUSE OF DEATH* was as follows:

Suicide by Illuminating Gas at home

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles Brooke, M. D.

4/29, 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 4/30 1930

20 UNDERTAKER William Cook

ADDRESS St Paul & Preston

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 56664 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56664

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 28-21 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr William V. Roach

(a) RESIDENCE NO. 4814 Frederick Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Roach

6 DATE OF BIRTH (month, day, and year) 8/15/1870

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	59	8	14	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER John Roach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Catherine Roach
(Address) 4814 Frederick Ave

15 Filed ....., 19 ..... RCH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-29 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-28 .19 30. to 4-29 .19 30.

that I last saw him alive on 4-29 .19 30,

and that death occurred, on the date stated above, at 9.25 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Ernest Spencer jr. ....., M. D.

, 19 (Address) St agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem — DATE OF BURIAL 5/1/30 19

20 UNDERTAKER Mary T. Ruth Bro 1735 — ADDRESS Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56665

REGISTERED NO. E 56665

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2917 E. Monument St., 7-11 Ward)

2-FULL NAME Henry E. Pryor

(a) RESIDENCE NO. 2917 E. Monument St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora H. Pryor nee Sands

6 DATE OF BIRTH (month, day, and year) Sept 28/1868

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	61	6	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George H. Pryor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Emma Staylor

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Mrs. Cora H. Pryor
(Address) 2917 E. Monument St

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol Shot Wound in head

Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John Callan, M. D.

4/29/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakdawn Cemetery

DATE OF BURIAL 5/1/30

20 UNDERTAKER Mary T. Ruth Sons

ADDRESS 1235 Hanover

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

233203 E 56666

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-001 E 56666

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~JOHNS HOPKINS HOSPITAL~~ ST., 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Hohman

(a) RESIDENCE NO. 1308 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~1~~ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May-11-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md-
(State or country)

PARENTS

10 NAME OF FATHER Frank Hohman

11 BIRTHPLACE OF FATHER (city or town) Md-
(State or country)

12 MAIDEN NAME OF MOTHER Sadie McGlinchy

13 BIRTHPLACE OF MOTHER (city or town) Md-
(State or country)

14 Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1930, to April 28, 1930, that I last saw him alive on April 28, 1930 and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukaemia

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Haemorrhage from intestine

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood studies

(Signed) J. W. Bickford, M. D.

4/28 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL 5/1/30

20 UNDERTAKER Mary T. Ruth Sons

ADDRESS 1935 Harford Ave

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 56667 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56667

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH U.S. Marine Hospital

CITY OF BALTIMORE: (No. Baltimore, Md. ST. 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Matthew Cook

(a) RESIDENCE NO. 1225 Pennsylvania Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

Important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond
(State or country) Virginia

PARENTS

10 NAME OF FATHER Sampson Cook

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary Harris

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Records, U.S. Marine Hospital
(Address) Baltimore, Md.

15 Filed 2 9 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28,1930

17 I HEREBY CERTIFY, That I attended deceased from October 16 29, to April 28 30,
that I last saw him alive on April 28 30,
and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of the heart

(duration) about 1 hour yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & laboratory findings

(Signed) Ralph L Porter M. D.

4/28 19 30 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va

DATE OF BURIAL 4/29 19 30

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Md

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56668

CERTIFICATE OF DEATH

E 56668

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mer St. Agnes Hospital St. Ward)

2-FULL NAME Mr Edith Doran

(a) RESIDENCE NO. Sykesville Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of David A Doran

6 DATE OF BIRTH (month, day, and year) Feb. 18= 1874.

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Wm J. Anthony

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Edith Braddock

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant George Doran
(Address) 1909 N. Bethel Ave. Balto

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

APR 29 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27 1930

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY
(Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Broosle, M. D.

Apr 29, 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brandenburg Cemetery	May 1st 1930

20 UNDERTAKER C. M. Watts Winfield, Md.
ADDRESS

IMPORTANT.—Physicians should make every effort to have this certificate supplied. Not only should be stated PLACE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 56669 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56669

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ..... St. 4-7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Ridgely

(a) RESIDENCE NO. Sewell Md St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed ....., 19..... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25-30

17 I HEREBY CERTIFY, That I attended deceased from 4-25, 1930, to 4-25, 1930, that I last saw him alive on 4-25, 1930, and that death occurred, on the date stated above, at 4 25 P. m.

The CAUSE OF DEATH* was as follows:

- Cystitis 133
- (Purulent obstruction ?) 135

(duration) ..... yrs. ..... mos 3T dys

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. 1 da.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. Leyko, M. D.
4/28, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lawnderee Cemetery

DATE OF BURIAL May 2 1930

UNDERTAKER Mary P Starr

ADDRESS Ellicott City

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Laura Margaret Ehrman

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56670

L 56670

CERTIFICATE OF DEATH

REGISTERED NO. 91 10 4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1172 Wilcox ST., 10-14 WARD)

2—FULL NAME Laura Margaret Ehrman

(a) RESIDENCE NO. 1172 Wilcox ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of George Ehrman

6 DATE OF BIRTH (month, day, and year) 2 2 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER William Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ida M. Shaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Robert Ehrman

(Address) 1172 Wilcox St

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/4, 1930, to 4/29, 1930, that I last saw h[er] alive on 4/28, 1930, and that death occurred, on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Several yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) Oedema of lungs (duration) 8 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Bernard Wolff, M. D.

4/30, 1930 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL May 1 1930

20 UNDERTAKER Stringer and Son Inc — ADDRESS 411 Broadway

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 56671

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56671

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST. 16-22 38 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Johnson

(a) RESIDENCE NO. 1009 N. Parish St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Johnson

6 DATE OF BIRTH (month, day, and year) Aug. 16, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond

(State or country) Va.

PARENTS

10 NAME OF FATHER Denton Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Millie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27-30

17 I HEREBY CERTIFY, That I attended deceased from 3-26-30, 19..., to 4-27-30, 19...,

that I last saw him alive on 4-27-30, 19...,

and that death occurred, on the date stated above, at 12:50 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta with aortic insufficiency.

Moyethon (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

Moyethon (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy, Wasserman.

(Signed) Paul Podgell, M. D.

4-29-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 1 1930
20 UNDERTAKER	ADDRESS
Virginia G. Brooks	1463 N. Carey

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 56672

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 56672

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp. ST. 15-21 WARD)

2-FULL NAME Betty Nichols

(a) RESIDENCE NO. 1700 Woodyear Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Nichols

6 DATE OF BIRTH (month, day, and year) Mar 28-1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Dennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Fannie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Record
(Address) .....

15 Filed APR 30 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28-30

17 I HEREBY CERTIFY, That I attended deceased from 4-16, 1930, to 4-28, 1930, that I last saw h[illegible] alive on 4-28, 1930, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchio pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

4-29 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr 30 1930
UNDERTAKER Francis A. Brooks	ADDRESS 1463 N Carey

FROM IS very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56673

CERTIFICATE OF DEATH

161-001

E 56673

1—PLACE OF DEATH Women's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 27-43 ST., WARD)

2—FULL NAME Dorothy Parks

(a) RESIDENCE NO. Women's Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 4/26/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	✓	✓	✓	20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ Nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William Francis Parks

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Dorothy Greenlaw

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Md.

14 Informant William F Parks

(Address) 5 Cedar Ave.

15 Filed APR 30 1930, 19 J. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 26, 19 30, to April 26, 19 30

that I last saw her alive on April 26, 19 30

and that death occurred, on the date stated above, at 10.55 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity (6 mo.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Hugh Brent, M. D.

. 19 (Address) 16 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	19
20 UNDERTAKER	ADDRESS

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.- 500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 56674

CERTIFICATE OF DEATH

E 56674

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 410 Mott ST. 5-8 WARD)

2—FULL NAME Henry Robinson

(a) RESIDENCE NO. 410 Mott ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	M

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Robinson

6 DATE OF BIRTH (month, day, and year) Aug 9 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S C

PARENTS

10 NAME OF FATHER Isaac Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) S C

12 MAIDEN NAME OF MOTHER Rebecca Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C

14 Informant Mrs Robinson

(Address) 410 Mott St

15 Filed APR 30 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27-30

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to April 27, 1930, that I last saw h alive on April 26, 30 and that death occurred, on the date stated above, at 130A m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatism

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) C. L. S. Allen M. D.

(Address) 508 Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hartsville S. C

DATE OF BURIAL April 30 1930

20 UNDERTAKER Mrs J. S. Locks

ADDRESS 1302 Jefferson

Important: See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56675 ✓ E 56675

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 508 E. 21st. St. (ST.) 9-46 (WARD)

2-FULL NAME George J. Hoyle.

(a) RESIDENCE NO. 508 E. 21st. St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Annie Fitzgerald Hoyle

6 DATE OF BIRTH (month, day, and year) March 5th. 1852

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	78	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Policeman. ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Police Dept.

9 BIRTHPLACE (city or town) (State or country) California.

PARENTS

10 NAME OF FATHER George A. Hoyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Eliza Lutts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs. Annie Fitzgerald Hoyle. (Address) 508 E. 21st. St.

15 Filed R 3 6 1930 19 C. HENRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1928, to April 28, 1930, that I last saw h— alive on April 28, 1930, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy - ~~abdominal~~

(duration) yrs. mos 10 da.

CONTRIBUTORY (Secondary) Natural organic - (duration) 1 yrs. ? mos. ? da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no.

What test confirmed diagnosis? none.

(Signed) [signature] M. D.

4/29, 19 (Address) 704 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL May 1st 19 30

UNDERTAKER Chas. F. Fraucht Son ADDRESS 118 W. Mt. Royal Ave

IMPORTANT. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56676 — CERTIFICATE OF DEATH — 129 — E 56676

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1031 N. Barre ST. (WARD) 21-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Fahrney

(a) RESIDENCE NO. 1031 N. Barre St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hagerstown Md

PARENTS

10 NAME OF FATHER John Fahrney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Faulkes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Louis. Fahrney

(Address) 1031 N. Barre St

15 Filed ... 1930 ... Registrar

C. HAWSON JONES, M. D.

APR 30 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 18, 1930, to Apr. 29, 1930, that I last saw her alive on Apr 29, 1930, and that death occurred, on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic Interstitial

indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) indefinite

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. G. Fruitnight M. D.

(Address) Apr 30 682 Park Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL May 1 1930

20 UNDERTAKER Henry Heidl Sons, Inc. — ADDRESS 1016 Eager St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 56677 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

129 E 56677

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 339 S. Payson ST. 20-28 (WARD)

2-FULL NAME Mrs. Elizabeth Eslinger

(a) RESIDENCE NO. 339 S. Payson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse Eslinger

6 DATE OF BIRTH (month, day, and year) Feb. 2-1842

7 AGE Years 88 Months 2 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Andrew [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

4/28/30

14 Informant (Address) Mrs. John Kaley 339 S. Payson St.

15 Filed ..... 19 ..... C. HAMPTON JONES, M. D. Registrar

Ref. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1930

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1930, to April 27, 1930, that I last saw h[illegible] alive on April 27, 1930 and that death occurred, on the date stated above, at 10 55 a. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage Arteriosclerosis Contributory Pulmonary Edema

(duration) ..... yrs. .....

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Herbert E. Nesbit, M. D.

(Address) 258 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL April 30 1930

20 UNDERTAKER George L. Schmidt

ADDRESS 2101 Eutaw Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56678 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56678

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 2814 Ulman ave ST., 15-54 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjaman Offit

(a) RESIDENCE NO. 2814 Ulman Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
Male	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Sarah Offit

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Harry Offit
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Michles
13 BIRTHPLACE OF MOTHER (City or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1434 E Balto St

15 Filed 4-30 1930 C. HAYDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/29/30

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to April 29th, 1930, that I last saw him alive on April 29th, 1930, and that death occurred, on the date stated above, at 10.15P m.

The CAUSE OF DEATH* was as follows:
angina Pectoris
(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) chr myocarditis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis?
(Signed) [illegible], M. D.
4/29, 1930 (Address) 2370 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kehreen Herring Run — DATE OF BURIAL 4/30 1930

20 UNDERTAKER Jack Lewis ADDRESS 1434 E Balto St

ATTENTION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56679

E 56679 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Mercy Hospl ST., 4-7 (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Hyman Rosenstock
(a) RESIDENCE NO. Ellicott City Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 45 yrs. 10 mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Rosenstock

6 DATE OF BIRTH (month, day, and year)	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
7 AGE	56yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Joseph Rosenstock
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Tobie Horowitz
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Pauline Rosenstock
(Address) Ellicott City Md

APR 30 1930 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30/30

17 I HEREBY CERTIFY, That I attended deceased from 4/20/30, 19..... to 4/30/30, 19.....
that I last saw him alive on 4/30/30, 19.....
and that death occurred, on the date stated above, at 4.40 p.m.

The CAUSE OF DEATH* was as follows:
Chronic bronchio-Vascular Renal Disease
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J Geyer, M. D.
4/30 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bath Hebrew
DATE OF BURIAL 5/1/ 1930
20 UNDERTAKER Jack Laurs ADDRESS 1429 Eutaw St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56680 (upper right) — REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 56680

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balt. Genl Hosp ST. WARD)

2-FULL NAME Moritz Ginsberg

(a) RESIDENCE NO. 2418 Callow Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Carrie Ginsberg

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 63 | Months — | Days —

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis
(Address) 1439 E Baltimore St

15 APR 30 1930 .. 19 .. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-29-1930

17 I HEREBY CERTIFY, that I attended deceased from Feb 25 1930 to April 29 1930

that I last saw h[illegible]ve on April 29 1930

and that death occurred, on the date stated above, at 10 40 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

over 7 Yrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (secondary) Diabetic Gangrene

Postoperative
(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 4-1-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) S A Klein M. D.

4/29 1930 (Address) West Balto Genl Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern

DATE OF BURIAL 4/30 1930

20 UNDERTAKER: Jack Lewis 1439 E Balto St

ADDRESS

Spec.—1-30—M. & T.—250 Blks.

E 56681 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56681

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital 2-K ST., WARD)

2-FULL NAME Jean Gleick

(a) RESIDENCE NO. 2033 E. Baltimore St., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	infant

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 7-1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Bennie Gleick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bell Katz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Bennie Gleick
(Address) 2033 E. Baltimore St

Filed APR 30 1930 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1930 to April 29, 1930, that I last saw her alive on April 29, 1930, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 6 yrs. 0 mos 19 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical + X ray

4/29 1930 (Signed) [illegible] M. D.
(Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mach Road — DATE OF BURIAL 4/30 1930

20 UNDERTAKER Jack Levin — ADDRESS E Balto St

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56682

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56682

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 631 W. Franklin ST. 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate Murray

(a) RESIDENCE NO. 631 W. Franklin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. - mos. - ds. How long in U. S., if foreign birth? 75 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Murray

6 DATE OF BIRTH (month, day, and year): Dec. 27, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Matthew Nooney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Gertrude Murray

(Address) 631 W. Franklin Street

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29-1930

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1930, to April 28, 1930, that I last saw h[illegible] alive on April 28, 1930, and that death occurred, on the date stated above, at 6.50 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms -

(Signed) Landon McKeown, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	5/2 19 30

20 UNDERTAKER: Henry W. Meats and Son ADDRESS 805 N. Calvert

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56683

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 56683

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 936 L. Pine St. 17-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jas. Rich

(a) RESIDENCE NO. 936 L. Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of Industry, business, or establishment in which employed (or employer) Steamer service

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Mary Rich

(Address) 936 L. Pine st.

15 Filed ....., 19.. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28/30

17 I HEREBY CERTIFY, That I attended deceased from Apr. 16, 1930, to Apr. 28, 1930,

that I last saw him alive on Apr. 28, 1930,

and that death occurred, on the date stated above, at 11:30 P.M. (D.S.T.)

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ....yrs. ....mos ....ds. —

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm A. Manuel M.D.

4/29/1930 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery

DATE OF BURIAL May 1 1930

20 UNDERTAKER Mrs. A. G. Ellicott

ADDRESS 1725 Edmondson

TION IS very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56684

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1 ✓

E 56684

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 244 Asquith ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cora Ellis

(a) RESIDENCE NO. 244 Asquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Ellis

6 DATE OF BIRTH (month, day, and year) Aug 5, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39	40	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wilmington (State or country) Del.

PARENTS

10 NAME OF FATHER Benj. Briggs

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Millie Thompson

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Edward Ellis

(Address) 244 Asquith St.

15 Filed APR 30 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1930, to April 28, 1930, that I last saw her alive on April 28, 1930 and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) XXXX

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. J. White, M. D.

, 19 (Address) 1021 Madison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Apr. 30 1930

20 UNDERTAKER Wm. H. Elliott

ADDRESS 1726 Ashland Ave

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 56685

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56685

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5509 Easter ave. ST., 27 43 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Sander

(a) RESIDENCE NO. 5509 Easter ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Harry Sander

6 DATE OF BIRTH (month, day, and year) April 3. 1874

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56	—	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER John G. Marr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Marr

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Russell Sander.
(Address) 5509 Easter ave

15 Filed C. HAMPSON JONES, M. D.
Registrar
MAY 2 0 1930
Date

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to April 29, 1930, that I last saw h alive on April 28, 1930 and that death occurred, on the date stated above, at 3. A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis & Exanition

Tuberculosis & exanition

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) Chas Jones, M. D.

April 29 1930 Address 4706 Hospital Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL May 1. 1930

20 UNDERTAKER Mr. & Mrs. John H. Feufel Son ADDRESS 821 W. Fayette St.

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 ✓ E 56686

CERTIFICATE OF DEATH

E 56686 REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1504 Dulles ST. 8-17 WARD)

2—FULL NAME Hennetta Cole

(a) RESIDENCE NO. 1504 Dulles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) VA

PARENTS

10 NAME OF FATHER Seldon Key

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hennetta Key

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Miss J Cole (Daughter) (Address) 1504 Dulles St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27-30

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to April 27, 1930, that I last saw h[illegible] alive on April 26, 1930 and that death occurred, on the date stated above, at 1.40 A m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardio Renal

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

Address 508 Fremont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL April 30 30

20 UNDERTAKER [illegible]

ADDRESS [illegible]

APR 30 1930 HAYDEN JONES, M. D.

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56687 (duplicate)

89 E 56687 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 4201 Park Heights Ave ST. 27-55 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Franklin Hall

(a) RESIDENCE NO. 4201 Park Heights Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charlotte Hall

6 DATE OF BIRTH (month, day, and year): June 3 1858

7 AGE — Years: 71 Months: 10 Days: 25 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John T. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Maudy Kidd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Charlotte Hall 4201 Park Heights Ave

15 Filed APR 30 1930 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29 1930

17 I HEREBY CERTIFY, That I attended deceased from April 10 1929 to April 29 1930,

that I last saw him alive on April 27 1930,

and that death occurred, on the date stated above, at 11.10 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Bacon M. D.

(Address) 99 W Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: May 1 1930

20 UNDERTAKER: J Vernon Kechner

ADDRESS 1932 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 56688 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56688

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St. 15-61 Ward)

REGISTERED NO. 88

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar Goodman

(a) RESIDENCE NO. 3406 - Duvall Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Rebecca B Goodman

6 DATE OF BIRTH (month, day, and year) May 26/1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Gents Toggery

(c) Name of employer Correspondent

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Isaac Goodman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosalie Bejarano

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

16 Informant Mrs Rebecca B Goodman

(Address) 3406 Duvall Ave

17 Date MAY 30 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1930

17

I HEREBY CERTIFY, That I attended deceased from April 15th, 1930, to April 29th, 1930,

that I last saw him alive on April 29th, 1930,

and that death occurred, on the date stated above, at 1:00 p. m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute anemia.

(duration) yrs. mos. 2 ds. prob

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/25/30.

Was there an autopsy? No.

What test confirmed diagnosis? operation.

(Signed) Samuel J Stamper, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ahavath Sholom

DATE OF BURIAL May 1st 1930

20 UNDERTAKER Harry Goodman & Son

ADDRESS 1121 W Lexington St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56689 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56689

74-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital Ward G 14 ST. 15-21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Abraham M. Goldstone

(a) RESIDENCE NO. 1647 N. Appleton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Pauline Goldstone

6 DATE OF BIRTH (month, day, and year) July 30th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	8	29	

8 OCCUPATION OF DECEASED 45

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture Business

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Michael Goldstone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Delta De Wolf

13 BIRTHPLACE OF MOTHER (city or town) Holland (State or country)

14 Informant Miss H. Goldstone

(Address) 1647 N. Appleton St.

15 4 30 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1930

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1930, to April 29, 1930, that I last saw h.. alive on April 29, 1930, and that death occurred, on the date stated above, at 8 40 P m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 30 yrs. mo ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Spinal Puncture

(Signed) Sandra F. Griglia M. D.

(Address) Mercy Hospital 4/29, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 5/2/1930

20 UNDERTAKER Harid Sondheim

ADDRESS 1520 W. Mt Royal Ave

TION is very important. See instructions on back of certificates.

R 30 1930

Spec.—1-10-21—M&T—1500 Bks.

E 56690

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56690

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 4-28-30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (City or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant .....
(Address) .....

15 Filed ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-29-30

17 I HEREBY CERTIFY, That I attended deceased from 4-28-30, 19..... to 4-29-30, 19.....,

that I last saw h... alive on 4-29-30, 19.....,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Premature (1) Month

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

..... 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL .....

DATE OF BURIAL ..... 19.....

20 UNDERTAKER .....

ADDRESS .....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 30 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001 E 56691

CERTIFICATE OF DEATH

E 56691

REGISTERED NO. 12-51

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2137 Huntingdon ST. WARD)

2—FULL NAME Marie Estelle Bennett

(a) RESIDENCE NO. 2137 Huntingdon Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Bennett

6 DATE OF BIRTH (month, day, and year) Jan 7 1894

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas O Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John E. Bennett

(Address) 2137 Huntingdon Ave

15 Filed APR 30 1930 WILLIAM F. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1930, to April 28, 1930, that I last saw h[illegible] alive on April 28, 1930 and that death occurred, on the date stated above, at 9:12 P m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goiter

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 2123 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: May 2 1930

20 UNDERTAKER: Chenoweth Low — ADDRESS: 2115 Eutaw

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

236196 M 56692

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 56692

CERTIFICATE OF DEATH

REGISTERED NO. 27-56

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 27-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William F Olmstead

(a) RESIDENCE NO. 4712 Delaware Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or WIFE of)~~ Ida B. Olmstead

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Olmstead

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Heuse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29-30

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to April 29, 1930, that I last saw h~~im~~alive on April 29, 1930 and that death occurred, on the date stated above, at 7 35 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Heart Disease

Myocardial Failure

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) James Bordley M. D.

4-30, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hanover Pa.

DATE OF BURIAL May 2, 1930

20 UNDERTAKER Chenoweth Son

ADDRESS 3615 Chestnut

Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56693

CERTIFICATE OF DEATH.

129 E 56693

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 511 Somerset St. 5-8 Ward)

2-FULL NAME J. Peter Bach

(a) RESIDENCE NO. 511 Somerset St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Bach

6 DATE OF BIRTH (month, day, and year) Oct 16 1844

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	85	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER Jacob Bach.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Driebach

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mary Bach.

(Address) 511 Somerset St.

15 Filed 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1930

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to April 28, 1930,

that I last saw h. alive on April 28, 1930,

and that death occurred, on the date stated above, at 5.2 p. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio Renal

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lloyd S. Adler, M. D.

April 2, 1930 (Address) 5568 Fairfax

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial 5/1/1930

20 UNDERTAKER Frank A. Tink ADDRESS 916 N. Gay

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 1930

Spec.—8-16-29—L. F. S.—100 Bks.

236/50 Aug. NE 56694

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56694

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Sheets

(a) RESIDENCE NO. Newcomerstown Ohio WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Althea Sheets

6 DATE OF BIRTH (month, day, and year) Aug 15, 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steel Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 079

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Sylvester Sheets

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records - JOHNS HOPKINS HOSPITAL (Address)

15 Filed APR 30 1930 G. HAMPSON JONES, M.D. Registrar APR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29-30

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1930, to April 29, 1930, that I last saw him alive on April 29, 1930 and that death occurred, on the date stated above, at 9 37 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor, glioma, benign

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia, lobular

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 24. IV. 30

Was there an autopsy? yes

What test confirmed diagnosis? operation

(Signed) E. H. Compton Jr. M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Comerstown Ohio

UNDERTAKER Schaad & Mitchell & Son

DATE OF BURIAL April 30 1930

ADDRESS 910 Eutaw Place

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56695

CERTIFICATE OF DEATH

182 E 56695

1-PLACE OF DEATH Found floating in the water at

City of Baltimore: (No. Foot of Cross St. St 24-33 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown. (C)

(a) RESIDENCE NO. Do not know. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	25	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Do not know.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report, S.D.
(Address)

15 Filed ....., 19.... C. RAWSON JONES, M. D. Registrar

APR 14

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Found April 25th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Probably accidental.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Leonhardt, M. D.

4/29, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
PUBLIC CEMETERY.

DATE OF BURIAL 19

20 UNDERTAKER
Commissioner of Health.

ADDRESS APR 30 1930

Per. Wm. E. WOODALL

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56696

CERTIFICATE OF DEATH

182 E 56696

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found floating in the water at 25-27

City of Baltimore: (No. E. & O. Coal Pier Curtis Bay St., Ward)

2-FULL NAME Unknown. (C)

(a) RESIDENCE NO. Do not know. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	40	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Do not know.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

15 Filed ....., 19.... V. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Found April 20, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Probably accidental.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Robt. Bernhardt, M. D.

4/20, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 -PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

Per. Wm. E. WOODALL

THE MORGUE.

Do not write above this line. PRINCIPAL CAUSE OF DEATH should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56697

E 56697

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma B. Diesel

(a) RESIDENCE NO. 806 S. Kenwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Diesel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Hominsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 30 1930, 19 Per Registrar

C. HAMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26-30

17 I HEREBY CERTIFY, That I attended deceased from Apr. 26, 1930, to April 26, 1930, that I last saw her alive on Apr. 26, 1930 and that death occurred, on the date stated above, at 3 15 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity 2 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes —

What test confirmed diagnosis?

(Signed) E. Vrieland, M. D.

4/26, 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: S HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health. — ADDRESS APR 30 1930

Dep. Reg. E. WOODALL

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56608 ✓ 31 E 56608

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Madison ave. ST., 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edna Harper

(a) RESIDENCE NO. 913 Madison ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Harper

6 DATE OF BIRTH (month, day, and year) [illegible] 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Harvey

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Annie Conby

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Annie Harvey (Address) 913 Madison ave

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

3 0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28-30

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1930, to April 28th, 1930

that I last saw h.ed alive on April 26th. 1930

and that death occurred, on the date stated above, at 6.30a.m.

The CAUSE OF DEATH* was as follows:

Acct. Parenchimatous Nephritis

(duration) ....yrs. ....mos. 28 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL May 1930

20 UNDERTAKER Mrs. M. A. Elliott

ADDRESS 1725 Ashland ave

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56699

CERTIFICATE OF DEATH

21

E 56699

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3814 Roland Ave ST. 13352 (WARD)

2—FULL NAME Lila V. Ayler

(a) RESIDENCE NO. 3814 Roland Ave ST., 13. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 2 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William H. Ayler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane R. Gladhetter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Rose E. Ayler

(Address) 3814 Roland Ave

MAY 3 0 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29-1930.

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1930, to April 29, 1930 that I last saw h.... alive on April 28, 1930 and that death occurred, on the date stated above, at 6.20 A. m.

The CAUSE OF DEATH* was as follows:

Cyanosis

(duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Coroner

(Signed) [illegible], M. D.

4/29, 1930 (Address) 8429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Marys (Hampden)

DATE OF BURIAL: May 1- 1930.

20 UNDERTAKER: Horace M. Burgee

ADDRESS: 363 Falls Road

Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56700

CERTIFICATE OF DEATH.

90 E 56700

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 2-4 Ward)

2-FULL NAME Minnie Smith

(a) RESIDENCE NO. 230 S. Duncan St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Smith

6 DATE OF BIRTH (month, day, and year) ? ? 1864

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
66	65	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Dinsmore

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Andrew Smith (Husband)

(Address) 230 S. Duncan

15 Filed 3 0 1930 16 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

Coroner and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bilateral Stenosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (secondary) Exhaustion

(duration) yrs. mos. 1 ds.

Apr 28 1930 (Signed) G C Bladen M. D.

(Coroner)

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Patrick's Cemetery Date of Burial May 2 1930

20 UNDERTAKER Henry Sander & Sons, Inc. ADDRESS Baltimore St. & Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 56701

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56701

CERTIFICATE OF DEATH

188-008

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. West Balto Gen Hosp 18-26 (Ward)

2-FULL NAME Ralph Blackwell.

(a) RESIDENCE NO. 304 N. Fremont St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Co | 5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Blackwell

6 DATE OF BIRTH (month, day, and year): July 12 1902

7 AGE: Years 27 | Months 9 | Days 16 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Driver
(b) General nature of industry, business, or establishment in which employed (or employer): Contractor
(c) Name of employer: Jas Keeley.

9 BIRTHPLACE (city or town): Va.
(State or country)

PARENTS

10 NAME OF FATHER: Lelland Blackwell

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: Rosie Pierce

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country)

14 Informant: Mary Blackwell
(Address): 304 N. Fremont

15 Filed MAY 1 - 1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident fell under wagon, Basilar Fractured Skull.

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary): Streptococcus Pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? 3500 Black Edmondson Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) F. Le Gendre M. D.

Apr 28th (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: May 1, 1930

20 UNDERTAKER: Wm. Katie R. Williams — ADDRESS 322 N Schroeder St

THIS SHOULD BE CAREFULLY ATTENDED TO AND SHOULD BE FILLED EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

Dr Curel 2105 N Charles St

E 56702

HEALTH DEPARTMENT—CITY OF BALTIMORE

3 E 56702

CERTIFICATE OF DEATH.

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 3425 University Place ST. (WARD)

2-FULL NAME Commodore Perry Long

(a) RESIDENCE NO. 3425 University Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie C Long

6 DATE OF BIRTH (month, day, and year) Dec 16, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Jennie C Long

(Address) 3425 University Place

15 Filed MAY 1 1930 H. C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 20, 1930, to Apr 30, 1930

that I last saw h[illegible] alive on Apr 28, 1930

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Dementia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Wm H Peake, M. D.

Apr 30, 1930 (Address) 2105 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

UNDERTAKER Wm Cook

DATE OF BURIAL 5/1 1930

ADDRESS 1217 E Pratt St

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

236460 Md E 56703

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

5 1 √ E 56703

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Esther Slater

(a) RESIDENCE NO. 1028 Cinquitts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John Slater

6 DATE OF BIRTH (month, day, and year) Aug- 22-1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Jeffers

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29. 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/28/30, 19..., to 4/29, 19 30, that I last saw h Cr alive on 4/29/30, 19..., and that death occurred, on the date stated above, at 745 P m.

The CAUSE OF DEATH* was as follows:

Diabetis - diabetic coma - Acidosis

duration diabetis?

Causal acidosis 36 hrs duration

(duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary) Hematemesis (duration) ...yrs. 1 mos. ? ...ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Hedwig Koenig, M. D.

. 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 5/2/ 1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

Important. See instructions on back of certificates.

MAY 1 - 1930 E. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 56704

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56704

100-001

CERTIFICATE OF DEATH

1-PLACE OF DEATH Balto City Hospls

CITY OF BALTIMORE: (No.) Balto Md ST., 9-14 (WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Hayden

(a) RESIDENCE NO. 1723 Lamont Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— Wd

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Eugene Lanahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Shine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Records Balto City Hospls

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-29-30

17 I HEREBY CERTIFY, That I attended deceased from 4-14-, 1930, to 4-29, 1930,

that I last saw alive on 4-29, 1930,

and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary) Senile Psychosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry J. Crosmun M. D.

4/29 1930 Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Towson Monte Marie Cemetery

DATE OF BURIAL 5/2/1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56705

CERTIFICATE OF DEATH

E 56705

REGISTERED NO. 181-20 E 56705

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4th Ward)

2-FULL NAME Thomas F. Ketler, (Jr)

(a) RESIDENCE NO. 763 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17 1874.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fish - Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas F. Ketler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Emma Conner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Thomas F. Ketler (Jr)
(Address) 745 N. Gay St.

15 Filed ..... 19.. ..... Registrar

MAY 1 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Poisoned by Co. Illuminating Gas. Accidental Death

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 763 W. Lexington St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Ketler, M. D.

5/1. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL May 2 1930

20 UNDERTAKER George Schilling & Son

ADDRESS N26 E Monument

IMPORTANT: ALL BLANKS should be carefully supplied. ARE SPACE for the stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. P. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56706

CERTIFICATE OF DEATH

74-001

E 56706

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lilly Hebron

(a) RESIDENCE NO. Annapolis Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F | 4 COLOR OR RACE: Black | 5 Single, Married, Widowed, or Divorced, (write the word): unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joe Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Katharine Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 3 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30-1930

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to April 30, 1930, that I last saw her alive on April 30, 1930 and that death occurred, on the date stated above, at 10.53 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Over 5 yrs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Medical examination

(Signed) Fred W Geil, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis, Md

DATE OF BURIAL 5/3 1930

20 UNDERTAKER Chas E Leeds & Co

ADDRESS 34 Nathan Annapolis

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56707

CERTIFICATE OF DEATH

45

E 56707

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John B. Spence

(a) RESIDENCE NO. 1325 N Caroline WARD Baltimore Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Spence

6 DATE OF BIRTH (month, day, and year) 1864 May 25

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Funeral Director

(b) General nature of industry, business, or establishment in which employed (or employer) Funeral Director

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo. N. Spence

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mrs. Jane Spence

(Address) 1325 N. Caroline St.

15 Filed MAY 1 - 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30/30

17 I HEREBY CERTIFY, That I attended deceased from 4/27, 1930, to 4/30, 1930, that I last saw him alive on 4/30, 1930, and that death occurred, on the date stated above, at 8 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma descending Colon with obstruction.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronco-pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? yes Date of 4/27/30

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Operation

(Signed) George Yeager, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL May 2 1930

20 UNDERTAKER Peter S. Lulo

ADDRESS 2300 Edmondson Ave

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 56708

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56708

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1705 Darley Ave ST. 8-45 (WARD)

2-FULL NAME Savannah Horner

(a) RESIDENCE NO. 1705 Darley Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Horner

6 DATE OF BIRTH (month, day, and year) Feb 11 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER James Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Marys Co. Md.

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Marys Co. Md.

14 Informant Edna N. Hoyle

(Address) 1705 Darley ave.

15 Filed MAY 1 - 1930 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30-1930

17 I HEREBY CERTIFY, That I attended deceased from 4/16, 1930, to 4/30, 1930, that I last saw h[illegible] alive on 4/30, 1930, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH was as follows:

Acute Pulm Oedema

Chronic Myocarditis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Senile Cystitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm L. S. Sadler, M. D.

4/30, 1930 (Address) 333 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR REMOVAL London Park Cemetery

DATE OF BURIAL May 3 1930

20 UNDERTAKER George W. Zinkler

ADDRESS 1737 E. Eager st

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56709

E 56709

CERTIFICATE OF DEATH

REGISTERED NO. 29

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2326 Druid Hill Ave ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Griffin

(a) RESIDENCE NO. 2326 Druid Hill Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs mos ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, Divorced, (write the word)
Male	Colored	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary E. Griffin

6 DATE OF BIRTH (month, day, and year) Oct 26 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	65	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hostler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Groucho Stables

9 BIRTHPLACE (City or town) Barkleysville Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Griffin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Brown

13 BIRTHPLACE OF MOTHER (City or town)
(State or country) Md

14 Informant Joseph Griffin

(Address) 2326 Druid Hill Ave

15 Filed ..., 19... Registrar C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30/30

17 I HEREBY CERTIFY, That I attended deceased from 4/16/30 to 4/30/30, 19..., that I last saw h... alive on 4/29/30, and that death occurred, on the date stated above, at 9.10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Interstitial Pneumonitis (duration) about 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical - Microscopical

(Signed) Sam Bayley, M. D.

5/1/30 (Address) 908 N Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL May 3 1930

20 UNDERTAKER Samuel Feldstein

ADDRESS 700 N Caroline

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56710

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56710

CERTIFICATE OF DEATH.

REGISTERED NO. 11-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 N. Amity ST. 18-26 WARD)

2-FULL NAME Clarence Chambers

(a) RESIDENCE NO. 228 N. Amity ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Alfred Chambers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hallie Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Crisfield, Md.

14 Informant Hallie Chambers (Address) 215 N. Amity St

15 Filed May 1 1930 19 C. HAMPSON JONES, M. D. Registrar

By —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30-30

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1930, to April 30, 1930, that I last saw him alive on April 29, 1930, and that death occurred, on the date stated above, at 1.20 p. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ....yrs. ....mos 16 ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical, Lab

(Signed) A Marco Williams, M. D.

4-30 1930 (Address) 1830 Madison ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL May 4, 1930

ADDRESS 3227 Schroeder St.

20 UNDERTAKER Chas Kotz R. W. Williams

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 56711 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56711

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Foltz

(a) RESIDENCE No. 421 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) May 31 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Frank Tambrino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna DeAulla

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hospital Record (Address)

15 Filed MAY 1 - 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30-30

17 I HEREBY CERTIFY, That I attended deceased from 4-17, 1930, to 4-30, 1930, that I last saw h[illegible] alive on 4-30, 1930, and that death occurred, on the date stated above, at 12 35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pelvis

Intestinal obstruction

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 4-17-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Pumphrey, M. D.

4-30 1930 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 3 1930
20 UNDERTAKER	ADDRESS
M. W. E. Dippel Inc	37 Conn

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56712

CERTIFICATE OF DEATH

E 56712

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hosp. St. 26-37 Ward)

2-FULL NAME Herman W. Diesel

(a) RESIDENCE NO. Eastern Ave near Riverside Drive, Ward Essex Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Diesel

6 DATE OF BIRTH (month, day, and year) July 4 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	33	9	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Paul Diesel

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER — " —

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Minnie Diesel
(Address) Eastern Ave near Riverside Drive

15 Filed MAY 1 - 1930 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
(Primary) Auto he was driving was struck by motor truck or as he was making turn
(Secondary) Fract Skull (duration) yrs. mos. ds.

CONTRIBUTORY

18 Where was disease contracted? If not at place of death? Eastern Ave Rd + Back Rd
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) [illegible], M. D.
4/1, 1930 (Address) 2939 W. Eldon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem. DATE OF BURIAL May 2 1930

20 UNDERTAKER Philip Herwig ADDRESS 206 Eutaw St

NOTE—Items should be carefully supplied. AGE should be stated EXACTLY. DISEASES should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56713 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001

CERTIFICATE OF DEATH

E 56713

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 N. Calhoun ST., 19-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jas. T. Alexander

(a) RESIDENCE NO. 525 N. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ~~Clarence Alexander~~

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Clarence Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) D.C

12 MAIDEN NAME OF MOTHER Judy Richerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C

14 Informant Clarence Alexander

(Address) 525 N. Calhoun St.

15 Filed MAY 1 - 1930 WILLIAM S. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 29, 1930, to May 1, 1930, that I last saw h... alive on Apr 30, 1930 and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Hatcher, M. D.

5/1, 1930 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

DATE OF BURIAL May 3 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans st

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56714 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56714

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO. 6-4 ST.....WARD)

2-FULL NAME Martha (Hobbins?) Martin

(a) RESIDENCE NO. 218 N. Durham ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? ——— yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Martin ?

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
over 50				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer ?

9 BIRTHPLACE (city or town) Eastern Shore of (State or country) Md

PARENTS

10 NAME OF FATHER Wm Hobbins ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md

12 MAIDEN NAME OF MOTHER Teenie ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant ..... (Address) Records

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30-30

17 I HEREBY CERTIFY, That I attended deceased from 4-23, 1930, to 4-30, 1930, that I last saw her alive on 4-30, 1930, and that death occurred, on the date stated above, at 4 15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic & acute

(duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McKeen, M. D.

4-30, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

DATE OF BURIAL May 3 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1691 Orleans st

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56715

CERTIFICATE OF DEATH.

× 41 E 56715

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No.) 6 Bluemont Ave (Ward) 9-11 GINDLESPERGER

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Lindlesperger

(a) RESIDENCE NO. 37 Admiral Rd (Ward) Lansdale.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna J. Lindlesperger

6 DATE OF BIRTH (month, day, and year) Dec. 23 1882

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
47	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor + Builder

(b) General nature of industry, business, or establishment in which employed (or employer) O'B

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Independence Ohio

PARENTS

10 NAME OF FATHER Henry Lindlesperger

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) U. S.
(State or country)

14 Informant Anna J. Lindlesperger
(Address) 37 Admiral Rd

15 Filed MAY 1 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-22-31, 19 ..... to 4-30-30, 19 .....,

that I last saw h alive on 4-30-31, 19

and that death occurred, on the date stated above, at 10:10 P m.

The CAUSE OF DEATH* was as follows:

Undetermined

Septicaemia (duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Thrombosis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 4-23-30

Was there an autopsy? No O'B

What test confirmed diagnosis? General Exam

(Signed) M. Hendrickson, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Little Shade Burial Ground

DATE OF BURIAL May 1 1930

20 UNDERTAKER Lilly + Gardner

ADDRESS 1 E. Saratoga St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56716 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56716

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. [illegible] ST., 576-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maytha E. Smith.

(a) RESIDENCE NO. Home Bostinia City Hospitals WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. no

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed 1930 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1925, to May 1, 1930, that I last saw h[illegible] alive on May 1, 1930, and that death occurred, on the date stated above, at 10:40 A. m.

The CAUSE OF DEATH* was as follows:

Syphilis of Central Nervous System; Tabes dorsalis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted, if not at place of death? In at Home & Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sero. Wasserman.

(Signed) Paul Padget. M. D.

5/1, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington. D. C. DATE OF BURIAL May, 1930

20 UNDERTAKER [illegible] ADDRESS [illegible] Pa

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 56717

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56717

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 Patapsco St. ST. 23-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Meyer

(a) RESIDENCE NO. 1223 Patapsco St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 3, 1852.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Katie Snow

(Address) 1223 Patapsco St., City

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

1-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1930

17

I HEREBY CERTIFY, That I attended deceased from March 28, 1930 to April 26, 1930

that I last saw h alive on April 26, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edda D. Cavalieri, M. D.

4/30 1930 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Cross Cemetery

DATE OF BURIAL 5/3 1930.

UNDERTAKER Frank H. Newell

ADDRESS Pikesville Md.

CAUSE OF DEATH must be plainly written, so that it may be properly classified. EXACT ATTENTION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 56718

Torrence

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 129 E 56718

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 253 W Hoffman St., 11-24 Ward)

2-FULL NAME Mamie Torrence

(a) RESIDENCE NO. 253 W Hoffman St., Ward Jacksonville Fla

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) 1894

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Floude

9 BIRTHPLACE (city or town) Floyd Handy
(State or country) Ga

PARENTS

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town) Ga
(State or country)
12 MAIDEN NAME OF MOTHER Nora Kilpatrick
13 BIRTHPLACE OF MOTHER (city or town) Ga
(State or country)

14 Informant Jessie Wright
(Address) 253 W Hoffman

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? 253 W Hoffman

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) C. E. Faith, M. D.

May 30 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jacksonville Fla	5/1 1930
20 UNDERTAKER Samuel J. Beesley	ADDRESS 578 N Eddy

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56719

CERTIFICATE OF DEATH

1671 E 56719

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2714 Fenwick Ave St. 8-46 Ward)

2-FULL NAME Nola Louisa Leitch

(a) RESIDENCE NO. 2714 Fenwick Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John H. Leitch

6 DATE OF BIRTH (month, day, and year) June 13/1890

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	39	10	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) A A Co., Md.

PARENTS

10 NAME OF FATHER William Tolson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Warren

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant John H. Leitch
(Address) 2714 Fenwick Ave

15 Filed ..... 19..... Registered ..... 19..... C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation
Suicide- Placed detached tube
from gas heater in mouth.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

4/30/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arnold. A.A.Co. Md	May 2 1930
20 UNDERTAKER	ADDRESS
Wm. Mus. John W. Teufel & Son	30 W. Fayette

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

Dr. Brickley 3337 Belvidere Ave Li 0543

E 56720

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56720

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3606 Spaulding Ave ST. 27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Hammerslough

(a) RESIDENCE No. 3606 Spaulding Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/23/1887

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Julian Hammerslough

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Cecilia Myers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Louis Hammerslough
(Address) 3606 Spaulding Ave

15 Filed ..... 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30/30

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1930, to April 30, 1930, that I last saw her alive on April 30, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 8 yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Occlusion of Coronary

Embolism (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. N. Brickley, M. D.

, 19 (Address) 3337 Belvidere Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 5/3/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56721

E 56721

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 6115 Bellona ave St. 27-45 Ward)

2-FULL NAME Estelle H. West

(a) RESIDENCE NO. 6115 Bellona ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULA S

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Della H. West

6 DATE OF BIRTH (month, day, and year): June 9th 1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58.	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: dispatcher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: United Rail Road

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: J. C. West

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Rebecca Hershberg

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Della H. West

(Address) 6115 Bellona ave

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (autopsy or inquiry.) thereon and from the evidence obtained by said inquest (autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. Wm. Rossiter M. D.

(Coroner)

5/1, 1930 (Address) 1632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial: 5/3/1930

26 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Complete answers to questions on this certificate are necessary for the protection of the family. Any omissions or errors should be carefully supplied. Avoid abbreviations. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56722

E 56722

CERTIFICATE OF DEATH

38

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital 18-29 ST., WARD)

2—FULL NAME Walter Joyave

(a) RESIDENCE NO. 13 Mt. Clark alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Annie Joyave

6 DATE OF BIRTH (month, day, and year) about 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Roofer-Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Thos Joyave

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Lottie Cummings

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co. Md
(State or country)

14 Informant Mrs Daniel C Akers
(Address) 2244 Wilkens Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1930.

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1930 to April 30, 1930

that I last saw h~~er~~ alive on April 30, 1930

and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows: Syphilis of heart & aorta

& Aortic Stenosis & insufficiency (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Uremia (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. H. Varney, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 5/3/ 1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

Important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

MAY 1 - 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 56723

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56723

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1912 McHenry ST., 20-28 WARD)

2—FULL NAME Catherine B Menke

(a) RESIDENCE NO. 1912 McHenry ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Menke

6 DATE OF BIRTH (month, day, and year) Jan 29 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John Hof

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mahnken

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Edith Menke

(Address) 1912 McHenry St

15 Filed 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1929 to April 30 1930

that I last saw h alive on April 29 1930

and that death occurred, on the date stated above, at 6.10 A m.

The CAUSE OF DEATH* was as follows:

Senility, Asthenia, Cachexia

Hypostasis — Chronic Interstitial Nephritis —

(doration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(doration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Nathan C Peters, M. D.

(Address) 2157 Wilkens Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western

DATE OF BURIAL 5/3 1930

20 UNDERTAKER Wm Cook

ADDRESS 1219 St Paul St

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—200 Mbs

Dr. M. Bowman Ford
626 N. Gilmor st ✓

E 56724 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56724

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 659 W. Franklin St. 17-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen M. Gray

(a) RESIDENCE NO. 659 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of George W. Gray

6 DATE OF BIRTH (month, day, and year) 9/9/1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) California

PARENTS

10 NAME OF FATHER John B. Richmond

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Rutherford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs Arthur Doberzr
(Address) 659 W. Franklin St

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1929, to Apr 30, 1930, that I last saw h[illegible] alive on Apr 26, 1930, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) Several yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia + Edema

[illegible] (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinal

(Signed) M Bowman Ford, M. D.

5/1, 1930 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL 5/3/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

MAY 1 1930 C. HAMPSON JONES, M. D. Registrar

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

Jr 20th 2720 Nbl. Ave.

E 56725 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56725

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2410 N. Charles ST. 12-51 WARD)

2-FULL NAME, Helen Downing Robinson

(a) RESIDENCE NO. 2410 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept-25-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John S. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Cordelia Downing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Powell D. Robinson

(Address) 2410 N. Charles St.

Filed May 1 1930 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1930

17 I HEREBY CERTIFY, That I attended deceased from 1922 to May 1 1930,

that I last saw h[illegible] alive on April 30 1930,

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Cor. Myocarditis

(duration) Some yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George M. Gayle, M. D.

5/1 1930 (Address) 4300 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount May

DATE OF BURIAL 5 1930

20 UNDERTAKER Wm Cook 12 E Saratoga St

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56726

CERTIFICATE OF DEATH.

+ 49 E 56726

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Aves (STREET OR WARD) 45-72

2-FULL NAME Morris Solowey

(a) RESIDENCE NO. 431 S 60th St. (STREET OR WARD) West Phila Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 4 ds. How long in U. S., if of foreign birth? 24 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Solowey

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
50				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hardware

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) ... (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham H. Solowey

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Russia

12 MAIDEN NAME OF MOTHER Celia Frank

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Russia

14 Informant Mrs. Dora Solowey

(Address) 431 S. 60th St. Phila Pa

15 Filed ... 1930 ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-1 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-29 1930 to 5-1 1930

that I last saw him alive on 5-1 1930

and that death occurred, on the date stated above, at 5.55 P m. Daylight Saving

The CAUSE OF DEATH* was as follows:

Chrondo-Sarcoma of Sternum

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Operation - Short Embolism

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 5/1/30

Was there an autopsy? No

What test confirmed diagnosis? Pathol. Laboratory

(Signed) Nicholas P. Bonelli A.B. M.D.

5/1 1930 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phila Pa

DATE OF BURIAL 5/1 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1429 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56727

46 ✓ E 56727

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2918 Winchester ST., 16-67 WARD)

2—FULL NAME Hortense E. Williams

(a) RESIDENCE NO. 2918 Winchester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: John E Williams

6 DATE OF BIRTH (month, day, and year): Sept 2 1875

7 AGE: Years 55 | Months 7 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Jno. P. Gittons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Matilda Standley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Jno E. Williams

(Address) 2918 Winchester St

15 Filed APR 2 1930, 19 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Apr, 1930, that I last saw her alive on Apr 28, 1930 and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix with Metastases

(duration) 1+? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (?) (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 1929

Was there an autopsy? No

What test confirmed diagnosis? Pathological Exam.

(Signed) Eugene F. D Mack, M. D.

, 19 (Address) 527 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 5/21 1930

20 UNDERTAKER: J. G. Moran

ADDRESS: 3000 E. Balto St.

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dupee.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56728

CERTIFICATE OF DEATH.

135 E 56728

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Joseph Hospital Caroline + Eden ST. 8 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Dupee

(a) RESIDENCE NO. 1206 Gorsham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE: Years 65 · Months · Days · If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant: Geo. Dupee (Address) 1206 Gorsham

15 Filed MAY 2 1930 HAMILTON JONES, M. D., Registrar

Per Rec

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-29 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-7 .1930. to 4-29 .1930.

that I last saw h[illegible]alive on 4-29 .1930.,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of Prostate

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) 1 yrs. 7 mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Wm. Kinder, M. D.

. 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Crem Va

DATE OF BURIAL: May 2, 1930

20 UNDERTAKER: Mrs. R. A. Elliott

ADDRESS 1125 Eastlander

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

56729

CERTIFICATE OF DEATH

E 56729

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 E. Center ST. 11-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henetta Mathews

(a) RESIDENCE NO. 110 E. Center ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Horace Mathews

6 DATE OF BIRTH (month, day, and year) Dec. 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Charles Co. (State or country) Md.

PARENTS

10 NAME OF FATHER John Lyons

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mary Marshall

(Address) 110 E. Center St.

15 Filed , 19 , Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30-1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 12, 1930, to Apr 29, 1930, that I last saw h[illegible] alive on Apr. 29 - 1930 8:30 P m. and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

with left hemiplegia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. exam.

(Signed) Max J. Keller, M. D.

5/1, 1930 (Address) 222 W. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Joseph's Cemetery

DATE OF BURIAL May 2, 1930

20 UNDERTAKER Max R. G. Elliott

ADDRESS 1420 Ashland Ave

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 56730

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56730

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Johns Hopkins Hosp. 569

City of Baltimore: (No.) St. (Ward)

2-FULL NAME Fred Hetron

(a) RESIDENCE NO. 425 N. Eden St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Hetron

6 DATE OF BIRTH (month, day, and year) 9-11-1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	63	7	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Insurance Agent
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John Hetron

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant Maddia Heebner
(Address) 425 N. Eden St

15 Filed ..... 19..... Registrar .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was as follows:
Struck by hit & run taxicab driven by Victor Feldgeman unapprehended

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract (C.C.) Tibia & Fibula - Severe Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baldwin & Caroline

Did an operation precede death? no Date of

Was there an autopsy? Yes P.M.

What test confirmed diagnosis? Clinical & Autopsy

(Signed) H. Braun M. D.

5/1, 1930 (Address) 639 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashley cemetery Md	5-2 1930
20 UNDERTAKER Wilt & Davis	ADDRESS 1113 N Eden

MAY 2 - 1930

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56731

CERTIFICATE OF DEATH.

3/ E 56731

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 N. Mount St. ST. 16-22 WARD)

2-FULL NAME Elton Staunton

(a) RESIDENCE NO. 721 N. Mount St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25-15

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	14	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ivor Va.

PARENTS

10 NAME OF FATHER James Stau nton

11 BIRTHPLACE OF FATHER (city or town) Ivor

(State or country) Va.

12 MAIDEN NAME OF MOTHER Carrie Keller

13 BIRTHPLACE OF MOTHER (city or town) Ivor

(State or country) Va.

14 Informant James Staunton

(Address) 721. n. mount St

15 Filed MAY 2 1930 HAMILTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4th. 1930 to Mayl 1930

that I last saw him alive on May 1 1930

and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Abt. 6 mts (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson M. D.

5-1-1930 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means, and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ivor Va

DATE OF BURIAL May 4 1930

20 UNDERTAKER Sam'l N. Chase & Son

ADDRESS 1400 Mahes

CAUSE OF DEATH must be entered plainly, so that it may be properly TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56732

CERTIFICATE OF DEATH

75-001

E 56732

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Hospital for Women of Md. ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Alida Gertrud Grimes

(a) RESIDENCE NO. Sherwood Hotel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. ~~How long in U. S., if foreign birth?~~ ~~yrs.~~ ~~mos.~~ ~~ds.~~

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of: Widowed 38 yrs Mr. Moses Lewis Grimes

6 DATE OF BIRTH (month, day and year): ~~January~~ 25th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Canandaigua N.Y. State.

PARENTS

10 NAME OF FATHER: Lafayette (Last name unknown)

11 BIRTHPLACE OF FATHER (city or town): Not known
(State or country): New York State

12 MAIDEN NAME OF MOTHER: ~~Alida Gertrude~~ Martha Hall

13 BIRTHPLACE OF MOTHER (city or town): Not known
(State or country): New York State

14 Informant: Mr. Allen A. Grimes (Son)
(Address): Hotel Sherwood, Balto

15 Filed MAY 2 - 1930 HARRY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 16th, 1930, to April 30th, 1930, that I last saw h[illegible] alive on April 30th, 1930, and that death occurred, on the date stated above, at 8:28 P. m.

The CAUSE OF DEATH* was as follows:

Immediate cause - Broncho-pneumonia

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary): Right hemiplegia

(duration) ... yrs. ... mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. G. Lynn III, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sand Ledge Mich.

DATE OF BURIAL: May 3 1930

UNDERTAKER: Steward & Mowen

ADDRESS: 7 W. Mt. Ave

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56733

CERTIFICATE OF DEATH.

89 E 56733

15-63

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4111 Ridgewood Avenue ST., 15 WARD)

2-FULL NAME Cecil Mullikin

(a) RESIDENCE NO. 4111 Ridgewood Avenue ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. — ds. How long in U. S., if of foreign birth? 63 yrs. 4 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Holt Mullikin

6 DATE OF BIRTH (month, day, and year) December-29-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	63	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager of Drug Department

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Wholesale Corp.

9 BIRTHPLACE (city or town) Talbot Co.,
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Thomas Mullikin

11 BIRTHPLACE OF FATHER (city or town) Talbot Co.,
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Anna L. Kemp.

13 BIRTHPLACE OF MOTHER (city or town) Talbot Co.,
(State or country) Maryland.

14 Informant Mrs. Cecil Holt Mullikin (Son)
(Address) 4111 Ridgewood Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-1-1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to May 1st, 1930.

that I last saw h[illegible] alive on May 1st, 1930

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm. G. Queen, M. D.

5/1, 1930 (Address) 350 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friend's Burial Ground	May 3/30
20 UNDERTAKER	ADDRESS
Stewart & Mowen Company	108 W. North Ave

CAUSE OF DEATH to plain terms, so that it may be properly classified. PENALTY FOR FAILURE OF CORRECT
TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

84 E 56734

CERTIFICATE OF DEATH

E 56734

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 Bolton ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jessie Elizabeth Grafflin

(a) RESIDENCE NO. 1204 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. 6 mos. 13 ds. How long in U. S., if foreign birth 87 yrs. 6 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct 18 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jacob H. Grafflin

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah E. Comegys

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mrs Florence L. Day (sister)

(Address) 1204 Bolton St

15 Filed MAY 2 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5th m, 1st day 1930

17 I HEREBY CERTIFY, That I attended deceased from April 13th, 1930, to May 1st, 1930, that I last saw her alive on April 30th, 1930, and that death occurred, on the date stated above, at 11 0 m.

The CAUSE OF DEATH* was as follows:

old age — general debility

(duration) ....yrs....mos....da.

CONTRIBUTORY (Secondary) old age — general debility

seven years (duration) ....yrs....mos....da.

18 Where was disease contracted if not at place of death? general sclerosis

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? irregular heart action

(Signed) A. J. Myers, M. D.

, 19 (Address) 1924 Mt Royal Ter —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 3 1930
20 UNDERTAKER Stewart & Company	ADDRESS Balto

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 56735

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 56735

15-68

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2140-W-North Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Samuel Lusk

(a) RESIDENCE NO. 2140-W-North Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowered

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet P. Lusk

6 DATE OF BIRTH (month, day, and year) May-2-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Lusk.

11 BIRTHPLACE OF FATHER (city or town) York Co. (State or country) Penna

12 MAIDEN NAME OF MOTHER Margaret Keatons

13 BIRTHPLACE OF MOTHER (city or town) York Co, (State or country) Penna.

14 Informant Mrs Lizzie E Smith (niece)

(Address) 2140-W-North ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2- 1930

17 I HEREBY CERTIFY, That I attended deceased from Past 3 yrs, 1927, to May 2, 1930, that I last saw h. alive on May 1, 1930, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Senile Coma.

Chronic Nephritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A Evans, M. D.

19 (Address) 612 N 40 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	May-5 1930.
20 UNDERTAKER	ADDRESS
Stewart Mortuary Co.	Balto.

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56736 × 92 ✓ E 56736

CERTIFICATE OF DEATH

E 56736

REGISTERED NO.

1—PLACE OF DEATH The Church Home - Infirmary (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Broadway ST., 6-9 WARD)

2—FULL NAME Mrs. Louisa Wirth

(a) RESIDENCE NO. Elmwood Ave & Elmwood Rd. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John P. Wirth

6 DATE OF BIRTH (month, day, and year) Jan 19, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER ? Sauers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rachael Elgar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John P. Wirth Jr

(Address) Elmwood & Maplewood Aves

15 Filed MAY 2 - 1930 HARRISON JONES, M Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1930

17 I HEREBY CERTIFY, That I attended deceased from April 28, 19 30, to April 29, 19 30, that I last saw h alive on April 29, 19 30 and that death occurred, on the date stated above, at 9:15 A m.

The CAUSE OF DEATH* was as follows:

Thrombosis of Left Coronary Artery

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of X

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Vernon H. Norwood, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

20 UNDERTAKER John Ulrich

DATE OF BURIAL May 2. 1930

ADDRESS 2008 Orleans

important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 56737

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74 1001

E 56737

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1329 Weldon Circle (Ward) 13-57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David D. Gaitside

(a) RESIDENCE NO. 1329 Weldon Circle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anna B. Gaitside

6 DATE OF BIRTH (month, day, and year) Dec 26 – 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min..
	68	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) Pool & Stout

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co.

(State or country)

PARENTS

10 NAME OF FATHER Wm N. Gaitside

11 BIRTHPLACE OF FATHER (City or town) Maryland

(State or country)

12 MAIDEN NAME OF MOTHER Eliza Armstrong

13 BIRTHPLACE OF MOTHER (city or town) Maryland

(State or country)

14 Informant Natalie Gaitside

(Address) 1327 Weldon Circle

15 Filed ____ 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 30 1930

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1930, to April 30, 1930, that I last saw h__ alive on April 30, 1930, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Epitelium

(duration) ____ yrs. ____ mos. 2 da.

CONTRIBUTORY (Secondary) Cerebral Hemiplegia

(duration) ____ yrs. ____ mos. 12 da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Frank H. Machen, M. D.

19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Date of Burial May 3 1930

20 UNDERTAKER A. S. Marshall ADDRESS 3537 Falls Road

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 2 - 1930 MARION JONES, M. D. Registrar

Spec.—1-30—M. & T.—250 Bks.

E 56738

E 56738

HEALTH DEPARTMENT—CITY OF BALTIMORE

33

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO. 22133

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nada Ogreta Fogle

(a) RESIDENCE NO. 127 F Hughes st. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Fogle

6 DATE OF BIRTH (month, day, and year) Dec. 12, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John W. Coulbourn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address)

15 Filed MAY 2 - 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to April 30, 1930,

that I last saw her alive on April 30, 1930,

and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of peritoneum

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic intestinal obstruction (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Glennon M. D.

4-30-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sherlock Md Via B. & O. R.R. — DATE OF BURIAL May 2 1930

20 UNDERTAKER John F. Denny — ADDRESS 715 Light

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

Scheuerman

E 56739 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56739

CERTIFICATE OF DEATH. 131

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Jos. Hospital (ST.) 9-12 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Scheuerman

(a) RESIDENCE NO. 813 N. Eugene Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Scheuerman

6 DATE OF BIRTH (month, day, and year): Oct 4, 1863

7 AGE: Years 66 Months 6 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 031
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS
10 NAME OF FATHER: Reinhold Wasserman
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Elizabeth Deibt
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Conrad Wasserman
(Address) 231 N. Kenwood Ave.

15 Filed MAY 2 1930, 19 HARRISON-JONES, INC. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/30/30 19

17 I HEREBY CERTIFY, That I attended deceased from 4/10/30, 19 ..., to 4/30/30, 19 ..., that I last saw h[illegible] alive on 4/30/30, 19 ..., and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Hydronephrosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/15/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Heidrich, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mathews

DATE OF BURIAL: May 4 1930

20 UNDERTAKER: Wm. E. Watkinson

ADDRESS 2334 Jefferson

Spec.—8-16-29—L. F. S.—100 Bks.

E 56740

HEALTH DEPARTMENT—CITY OF BALTIMORE

21 E 56740

CERTIFICATE OF DEATH

REGISTERED NO. 12-457

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Hardy Powell

(a) RESIDENCE NO. 205 Stony Run Lane WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Mary E. Bonsack

6 DATE OF BIRTH (month, day, and year) Dec. 8 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9 BIRTHPLACE (city or town) York Pa (State or country)

PARENTS

10 NAME OF FATHER Rev Arthur Chilton Powell

11 BIRTHPLACE OF FATHER (city or town) Dayton (State or country) Ohio

12 MAIDEN NAME OF MOTHER Helen B. Hardy

13 BIRTHPLACE OF MOTHER (city or town) Columbus (State or country) Ohio

14 Informant Rev A. Chilton Powell

(Address) 2010 Stoney Run Lane

MAY 2 - 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-2-30

17 I HEREBY CERTIFY, That I attended deceased from 4-26, 1930, to 5-2, 1930, that I last saw him alive on 5-2 —, 1930 and that death occurred, on the date stated above, at 145 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia — 6 days

Empyema — 8 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis & Valvular heart disease ?

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore - (Home)

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon K. Norwood, M. D.

. 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL May 3rd 1930

20 UNDERTAKER Henry H. Jenkins Sons Co

ADDRESS McCulloh & Orchard Sts.

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56741 — 43 E 56741

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., 10-14 WARD)

2-FULL NAME Elijah (Former) McDaniel

(a) RESIDENCE NO. 704 Emma ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 3-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
[redacted]	63	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Kentucky

PARENTS

10 NAME OF FATHER John McDaniel

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Arkansas

12 MAIDEN NAME OF MOTHER Henrietta Veach

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Hospital Record
(Address)

15 Filed MAY 2 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30-30

17 I HEREBY CERTIFY, That I attended deceased from 1-22, 1929, to 4-30, 1930,
that I last saw him alive on 4-30, 1930,
and that death occurred, on the date stated above, at 11 1/4 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of lower lip with local metastasis.

(duration) 1 yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 1928

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Fred M. Underhill, M. D.

19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL May 2 1930

20 UNDERTAKER Henry Lutz

ADDRESS 1203 N. Broadway

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56742

CERTIFICATE OF DEATH.

11-24 129

E 56742

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 N. Eutaw St. 11-24 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Douglass

(a) RESIDENCE NO. 908 Eutaw ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E.

6 DATE OF BIRTH (month, day, and year) Sept. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Luncheon Owner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Sarah E. Douglass
(Address) 908 Eutaw St

15 Filed ....., 19 ..... Registrar

MAY 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 19 30

17 I HEREBY CERTIFY, That I attended deceased from January 7, 19 30, to May 1, 19 30,
that I last saw him alive on April 29, 19 30,
and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pelletier, M. D.

, 19 (Address) 811 Hamilton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leesburg Va

DATE OF BURIAL May 4 1930

20 UNDERTAKER Charles Hale & Son

ADDRESS 1406 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56743

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56743

CERTIFICATE OF DEATH.

1804 Park Ave 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Pimlico Hospital St. 15-21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Mast

(a) RESIDENCE NO. 1517 St. Fulton ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie Mast

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE — Years: 56 — Months: — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Shoe

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jennie Mast (Address) 1517 N. Fulton ave

15 Filed ..., 19... Per ... Registrar

MAY 2 = 1930 C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1 - 1930

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1930, to May 1, 1930; that I last saw him alive on May 1, 1930, and that death occurred, on the date stated above, at 3.43 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of left femur

about (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam. & X Ray

(Signed) Nathan H. Shapiro, M. D.

, 19 (Address) 2318 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Work Road

DATE OF BURIAL: 5-2- 1930

20 UNDERTAKER: Jack Lewis, 1438 E Balto

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—1-16-21—M&T—1500 Blks.

E 56744 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. X 47 E 56744

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St 25-72 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Wiley

(a) RESIDENCE NO. 407 W. Market York Pa ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
53				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr Charles Wiley
(Address) 407 W. Market St Yorkville

15 Filed MAY 2 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-2 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-27, 1930, to 5-2, 1930, that I last saw her alive on 5-2, 1930, and that death occurred, on the date stated above, at 2.40 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia -

(duration) ... yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Carcinomatosis - Ca. Breast.

(duration) 2 yrs. ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At Home -

Did an operation precede death? No Date of -

Was there an autopsy? No -

What test confirmed diagnosis? No -

(Signed) Hjalmer S. Anderson, M. D.

5-2, 1930 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL York Pa.

DATE OF BURIAL May 5 1930

20 UNDERTAKER Thomas D Lon

ADDRESS 3615 Chestnut

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 ✓

REGISTERED NO. E 56745

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1228 Madison ST. 10-14 WARD)

2—FULL NAME Henrietta Stevens

(a) RESIDENCE NO. 1228 N. Madison ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo W Stevens

6 DATE OF BIRTH (month, day, and year): 8 1871

7 AGE: Years 59 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dantes

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Antrum Gilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Samantha Gilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Sophia Boston (daughter)
(Address) 1528 E. Madison st

15 Filed MAY 2 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29 30

17 I HEREBY CERTIFY, That I attended deceased from April 26, 19.., to April 29, 1930, that I last saw h alive on April 29, 1930 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? ? Date of

Was there an autopsy? ?

What test confirmed diagnosis? Physical

(Signed) Geo Allen, M. D.

5-2, 1930 (Address) 508 Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cemetery — DATE OF BURIAL: May 2 1930

20 UNDERTAKER: Robert McKeever — ADDRESS: 1518 McCulloh St

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 56746 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56746

CERTIFICATE OF DEATH. 57V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland Ave (ST.) 1424 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada V. Hawkins

(a) RESIDENCE NO. Seven Rd Villa Nova (ST.) WARD Mt Airy Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James O. Hawkins

6 DATE OF BIRTH (month, day, and year): Dec 13-1884

7 AGE: Years 45 yrs | Months 4 | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Mount Airy Md.

PARENTS

10 NAME OF FATHER: Valentine Horn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Hannah Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Hosp. Records

15 MAY 2 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-30 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-27-30, 19..., to 4-30-30 19...

that I last saw her alive on 4-30-30, 19...,

and that death occurred, on the date stated above, at 4.55 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Diabetic Coma

(duration) yrs. mos. 18 hrs.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Thompkins, M. D.

4/30 1930 (Address) Church Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery.

DATE OF BURIAL: May 2 1930

20 UNDERTAKER: Joseph H Cook

ADDRESS: 1003 West Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—10[illegible] Bks.

E 56747 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 56747

CERTIFICATE OF DEATH

REGISTERED NO. 18-76

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. Provident Hospital ST. 18-76 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Evelyn Butler

(a) RESIDENCE NO. 221 N. Schroeder ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored.	Single.

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 25 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	8	6	5.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Schoolgirl.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Washington
(State or country) D.C.

PARENTS

10 NAME OF FATHER Bernard Butler

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country) D.C.

12 MAIDEN NAME OF MOTHER Mary Mathews.

13 BIRTHPLACE OF MOTHER (city or town) Washington
(State or country) D.C.

14 Informant Francis Clarke
(Address) 221 N. Schroeder St.

15 Filed MAY 2 - 1930 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl. 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1930, to Apl. 30, 1930, that I last saw h[illegible] alive on Apl. 30, 1930 and that death occurred, on the date stated above, at 10.40 a.m.

The CAUSE OF DEATH* was as follows:
Meningitis (Pneumococcic)

(duration) yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Carroll M St Clair, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 5-3 1930

20 UNDERTAKER David Carton

ADDRESS 916 Pacific

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56748

CERTIFICATE OF DEATH

129 ✓

REGISTERED NO. E 56748

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4704 Delaware ave ST. 27-56 WARD)

2—FULL NAME William Henry Busch

(a) RESIDENCE NO. 4704 Delaware Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) January 7-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	11	23 da	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night-watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Transportation

(c) Name of employer Baltimore Steamship Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Abraham V. B. Busch

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Pujjin

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Irene Robins
(Address) 4704 Delaware ave.

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30-1930

17 I HEREBY CERTIFY, That I attended deceased from October 15- 1928, to April 30- 1930,
that I last saw him alive on April 26- 1930
and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Uremia & Physical Signs.

(Signed) Chester Roland, M. D.

4-30-1930 (Address) 2532 Edmondson ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 5/3 1930

20 UNDERTAKER John J. Fahey Sons

ADDRESS 1318 Light St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56749 ✓ E 56749

E 56749

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 12-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Johnson

(a) RESIDENCE NO. 408 Wasley ST., 408 Worsley St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sent here from city Jail.

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed 4-28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27-30.

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1930, to April 27, 1930, that I last saw him alive on April 27, 1930, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? City Jail

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyko, M. D.

4/27, 1930 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: MAY 1 - 1930

20 UNDERTAKER: Commissioner Health.

ADDRESS

Rep. Wm. E. Woodall

Spec.—1-30—M. & T.—250 Bks.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56750

E 56750

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5008 Benefont Ave) WARD 27th

2-FULL NAME. Infant Harrison

(a) RESIDENCE. No. 1205 Sabina Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) April 30. 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Ralph Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ruby Kinnamon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Ruby Harrison 1205 Sabina Ave

15 Filed MAY 2 - 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1930

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1930, to April 30, 1930, that I last saw her alive on April 30, 1930, and that death occurred, on the date stated above, at 10½ P. m.

The CAUSE OF DEATH* was as follows:

5½ hrs Miscarriage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) G. N. Beasley, M. D.

19 (Address) 3357 Belvedere Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

MAY 1 1930

Per Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56751

100-001

E 56751

CERTIFICATE OF DEATH

27-43

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 6812 Harford Ave St., (Ward)

2-FULL NAME Adam L. Preisinger

(a) RESIDENCE NO. 6812 Harford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence lo city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14, 1930

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	1	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER John H. Preisinger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Edna Volker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md

14 Informant John H. Preisinger
(Address) 6812 Harford Ave.

15 Filed MAY 2 - 1930 H. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. S. H. Collins, M. D.
5/2/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 2 1930
20 UNDERTAKER Henry Hoech Sons Inc.	ADDRESS 130 E E.

You should be careful supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 56752

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56752

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1425 W. Fayette St. 14-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Curtis

(a) Residence No. 1425 Fayette St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 4/30/30

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 3 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... 0.0.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore, Md

(State or Country).

PARENTS.

10-NAME OF FATHER, Howard Curtis

11-BIRTHPLACE OF FATHER (city or town) Balt., Md

(State or Country).

12-MAIDEN NAME OF MOTHER. Eliz Allison

13-BIRTHPLACE OF MOTHER (city or town) Virginia

(State or Country).

11-

(Informant).....

(Address).....

15-

Filed ..... 19?

Registrar.

1930 16006

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-30-30

17- I HEREBY CERTIFY, That I attended deceased from Apr. 30. 1930 to Apr. 30. 1930.

that I last saw h[illegible] alive on Apr 30 1930

and that death occurred, on the date stated above, at 12 p.m.

The CAUSE OF DEATH* was as follows:

Abortion (16 weeks).

S. Bas Emeras

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....

(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible] M. D

5/4 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. HOPKINS HOSPITAL

DATE OF BURIAL. ..... 19....

20-UNDERTAKER, Commissioner Health.

ADDRESS MAY 2 - 1930

C. HAMPSON JONES, M.D. Registrar.

Instructions on back of certificates.

Be sure to state, so that it may be properly classified, EXACT statement of OCCUPATION in very important case

Spec.—1-30—M. & T.—250 Bks.

E 56753

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56753

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 5-8 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Thomas

(a) RESIDENCE NO. 120 Matthews st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	49			
46				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) UNIVERSITY OF MARYLAND

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1930, to April 30, 1930,

that I last saw him alive on April 30, 1930,

and that death occurred, on the date stated above, at 11.25 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. Chenoweth Jr., M. D.

5-1 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS MAY 2

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56754

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56754

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T. 5.) 21
CITY OF BALTIMORE: (NO. ..... ST. 15 WARD)

2-FULL NAME Roberta M. Elliott

(a) RESIDENCE NO. 1700 Baker st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 29, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10 NAME OF FATHER "Doc" Elliott
11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia
12 MAIDEN NAME OF MOTHER Bessie Jones
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address) UNI

15 Filed 2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1930, to April 29, 1930,
that I last saw her alive on April 29, 1930,
and that death occurred, on the date stated above, at 7.30 p. m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.
4-30, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND
DATE OF BURIAL 19
ADDRESS MAY 2

20 UNDERTAKER Commissioner of Health.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56755

E 56755

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital) 6-10 WARD)

2-FULL NAME Edward Keller

(a) RESIDENCE NO. 4 N. Glover ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Aug 1, 1923

7 AGE: Years 6 Months 8 Days 28 29

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Joseph A. Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Ada Whelden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. Ada Keller

(Address): 4 N. Glover St.

15 Filed ..... 19 ..... Registrar .....

C. HAMPSON JONES, M. D.

MAY 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/30/30 19

17 I HEREBY CERTIFY, That I attended deceased from 4-24-30, 19..., to 4-30-30, 19...,

that I last saw him alive on 4-30-30, 19...,

and that death occurred, on the date stated above, at 3.55 A. m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic Fever with carditis.

(duration) yrs. 1½ mos ..... ds.

CONTRIBUTORY (Secondary): Acute cardiac dilatation

(duration) yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. B. Kerr, M. D.

19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: May 3 1930

20 UNDERTAKER: John A. Braun

ADDRESS: 3000 E. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56756

CERTIFICATE OF DEATH

100-001 ✓ E 56756

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1412 Bolton ST. (or AVE.) 14-20

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Thomas Brown

(a) RESIDENCE NO. 1412 Bolton ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 4 mos. 9 ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Lydia Brown

6 DATE OF BIRTH (month, day, and year) Dec 23-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Purchasing Agt

(b) General nature of industry, business, or establishment in which employed (or employer) 586

(c) Name of employer Spring Grove Hosp.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Saml. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

11 Informant Florence A. Brown

(Address) 1412 Bolton St

15 Filed ... 19... Registrar C. HAMPSON JONES, M. D.

1 - 1930 Pat ...

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5, 8, 30

17

I HEREBY CERTIFY, That I attended deceased from 4.24 1930, to 5.2 1930.

that I last saw him alive on May 1st 10 P. M. 1930

and that death occurred, on the date stated above, at 8.40 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. D. Bolton, M. D.

5.2. 1930 (Address) 711 N Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL May 5 1930

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1944 W. North Ave

Spec.—1-10-21—M&T—1500 Bks.

E 56757

HEALTH DEPARTMENT—CITY OF BALTIMORE

32E 56757

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital
CITY OF BALTIMORE: (No. ..... ST. 30-17 WARD)
2-FULL NAME Emmett W. Ledley
(a) RESIDENCE No. 1848 W. Mulberry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 21 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 21, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21	1	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerical
(b) General nature of industry, business, or establishment in which employed (or employer) Zell Motor Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS
10 NAME OF FATHER Carroll W Ledley
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland
12 MAIDEN NAME OF MOTHER Viola Haring
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Hospital Records
(Address)

15 Filed MAY 2 - 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1930

17 I HEREBY CERTIFY, That I attended deceased from April 30 1930 to May 1 1930
that I last saw him alive on May 1 1930,
and that death occurred, on the date stated above, at 5 00 P m.

The CAUSE OF DEATH* was as follows:

Abscess of nose 99-001

(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) basal meningitis 320
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no Spinal fluid
What test confirmed diagnosis? clinical examination
(Signed) Jno A Lungstrum M.D.
(Address) Balto Gen Hosp

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL May 3 1930.
20 UNDERTAKER Mr. Mrs. J. W. Teufel & Son ADDRESS 801 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 56758

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 56758

CERTIFICATE OF DEATH

1—PLACE OF DEATH Walbert Apartments REGISTERED NO. 12-70

CITY OF BALTIMORE: (No. Charles & Lafayette ave. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie E. Garner

(a) RESIDENCE No. Walbert Apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of James W. Garner

6 DATE OF BIRTH (month, day, and year) July 14-1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	89	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New Bern

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Alexander Mitchell

11 BIRTHPLACE OF FATHER (city or town) New Bern

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Fanny Sears Jerkins

13 BIRTHPLACE OF MOTHER (city or town) New Berne

(State or country) North Carolina

14 Informant H. & B. Latham

(Address) 3213 Hound Park ave

15 Filed 12-1938 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1-1930

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1929, to May 1, 1930,

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 10-30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute intestinal obstruction

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) Wm. L. Whitehead, M. D.

5 V. 1930 (Address) 711 W. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL May 3 1930

20 UNDERTAKER Chas. G. Black

ADDRESS 742 W. North ave

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

No Francis 2939 McElderry St Friday a. m.

E 56759 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56759

CERTIFICATE OF DEATH. 122-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5102 Eastbourne Ave ST., 26-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Evans Sr

(a) RESIDENCE NO. 5102 Eastbourne Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed or divorced~~ HUSBAND of ~~or) WIFE of~~ Eleanor M. Evans

6 DATE OF BIRTH (month, day, and year) Jan 8th 61

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER William Evans

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF ~~Mother~~ Jane Wolf

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Eleanor M. Evans

(Address) 5102 Eastbourne Ave

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30-30

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 28 to 4-30 19 30

that I last saw him alive on 4-30 19 30

and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows: Chr Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis (Chronic) (?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) 30 J. Evans, M. D.

5-7, 19 (Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Park Cemetery

DATE OF BURIAL 5/1/ 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56760 — 167-001 — E 56760

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Square Hospital Ward)

2-FULL NAME Millie M Cox

(a) RESIDENCE NO. 121 S. Payson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Cox

6 DATE OF BIRTH (month, day, and year) Oct. 16/1863

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	66	6	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H. W.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Chas Albaugh

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Isabella Albaugh

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant John H Cox
(Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiring (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiring (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by illuminating gas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. A. Browne, M. D.

May 2, 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	5/5 1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 2 - 1930

Spec.—1-12-21—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56761

129 E 56761

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1622 W. Franklin (ST.) (WARD) 14-27

2-FULL NAME John William Payne

(a) RESIDENCE NO. 1622 W. Franklin ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Payne

6 DATE OF BIRTH (month, day, and year): March 10, 1885

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min
45	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Laboring work

(c) Name of employer: Swintz Stone Quarry

9 BIRTHPLACE (city or town) (State or country): Orange Co. Va.

PARENTS

10 NAME OF FATHER: William H. Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Orange Co. Va.

12 MAIDEN NAME OF MOTHER: Betty Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Orange Co. Va.

14 Informant: Annie Payne

(Address): 1622 W. Franklin St.

15 [illegible] 2 - 1930 . 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29, 30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10 . 19 29 to April 29 . 19 30.

that I last saw him alive on April 10 . 19 30

and that death occurred, on the date stated above, at 9:15a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interatitial Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Act. Parenchemitous Neph.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson, M. D.

. 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: May 3 1930

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1303 Presstman St

C. HAMPSON JONES, M. D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ...

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56762

CERTIFICATE OF DEATH

E 56762

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2121 Ethel St) (Ward) 14-59

2-FULL NAME Maggie Lee

(a) RESIDENCE NO. 2121 Ethel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Lee

6 DATE OF BIRTH (month, day and year): 1877 - May 23rd

7 AGE: Years 53 | Months 1 | Days 5 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Md.
(State or country)

PARENTS

10 NAME OF FATHER: Westley Boyce

11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Margaret

13 BIRTHPLACE OF MOTHER (city or town): Md.
(State or country)

14 Informant: Louis Lee
(Address) 2121 Ethel St

15 Filed ... 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 28th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

Sudden

(duration) ....yr. ....mos. ....da.

CONTRIBUTORY (Secondary) – Error of Diet

(duration) 2 yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) ....M. D.

(Address) 1 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: May 3 1930

20 UNDERTAKER: Thomas E Kelson — ADDRESS: 1307 Pennsylvania Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56763

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56763

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) President Hosp ST. 14-20 (WARD)

2—FULL NAME Maud E. Jackson

(a) RESIDENCE NO. 2016 Druid Hill ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Moses L Jackson

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Clem. Harper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ellen Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Moses Jackson

(Address) 2016 Druid Hill Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30/30

17 I HEREBY CERTIFY, That I attended deceased from 4/23 19 30, to 4/30 19 30,

that I last saw h alive on 4/30 19 30

and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) B Farris, M. D.

4/30 1930 (Address) President Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 5/3 1930

20 UNDERTAKER Thomas E Kelson.

ADDRESS 1307 Pennsylvania Ave

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56764

CERTIFICATE OF DEATH

E 56764

REGISTERED NO. 31

1—PLACE OF DEATH

CITY OF BALTIMORE: (a) Provident Hospital ST., 11-24 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Robinson

(a) RESIDENCE NO. 1025 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1880(?)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer gen'l

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER George W. Robinson

11 BIRTHPLACE OF FATHER (city or town) Matthews Co
(State or country) Va.

12 MAIDEN NAME OF MOTHER Amanda Griffin

13 BIRTHPLACE OF MOTHER (city or town) Lancaster
(State or country) Va.

14 Informant Amanda Robinson
(Address) 417 Druid St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30-30

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1930, to April 30, 1930, that I last saw him alive on April 30, 1930, and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) about 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) Carroll M St Clair, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL May 3 1930

20 UNDERTAKER Samuel S. Hamilton

ADDRESS 5716 Belair Rd

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56765 ✓ 45 E 56765

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1536 Argyle ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James H. Payne

(a) RESIDENCE NO. 1536 Argyle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years 59 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Waiter Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Isabelle Lee

(Address) 1921 Druid Ave

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1930, to April 30, 1930

that I last saw him alive on April 30, 1930

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Carey, M. D.

, 19 (Address) 1532 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem. DATE OF BURIAL: May 3 1930

20 UNDERTAKER: Samuel Stanley & Bro. ADDRESS 1118 Pine

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56766

CERTIFICATE OF DEATH

29 E 56766

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1937 Druid Hill ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Hayes

(a) RESIDENCE NO. 1937 Druid Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida B Hayes

6 DATE OF BIRTH (month, day, and year): Sept. 22, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	65	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Henry B Wolfe

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Thomas C Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va

12 MAIDEN NAME OF MOTHER: Rose Downs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Ida B Hayes

(Address): 1937 Druid Hill

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-30-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1930 to April 30, 1930

that I last saw him alive on April 30, 1930

and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Aortic Stenosis

(duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) H. W. Rogers, M. D.

5/1, 1930 (Address) 120 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: May 3rd 1930

20 UNDERTAKER: Samuel S. Hemsley

ADDRESS: 978 Bond

Of death in plain terms, so that it may be properly classified. important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 56767 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56767

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp. (St.) 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvin Wm Berry

(a) RESIDENCE NO. 1619 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1545

7 AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
	85?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maria Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address)

15 Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-2-30

17 I HEREBY CERTIFY, That I attended deceased from 4-25, 1930, to 5-2, 1930, that I last saw him alive on 5-1, 1930, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. L. Lumpkin, M. D.

5-2, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL May 3 1930

20 UNDERTAKER Samuel Hensley & Bro ADDRESS 528

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 56768

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56769

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 21 Mercy Hospital

CITY OF BALTIMORE: (No.) Caroline (St.) 1 (Ward)

REGISTERED NO. 11

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Wilson

(a) RESIDENCE NO. 323 N Bruce St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Wilson

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE Years 40 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Enoch Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucy Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Henry Wilson

(Address) 323 N Bruce St

15 Filed MAY 2 1930, 19

CHARLES H. THOMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-1- 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-21-30, 19, to 5-1-30, 19,

that I last saw h alive on 5-1-30, 19,

and that death occurred, on the date stated above, at 8:2 a m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/29/30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Wm Lindsay, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem | DATE OF BURIAL May 3 19 30

20 UNDERTAKER Samuel A Fowler | ADDRESS 1211 E Baltimore St

MAY 2 1930

Registered

Spec.—1-10-21—M&T—1500 Bks. HEALTH DEPARTMENT—CITY OF BALTIMORE CERTIFICATE OF DEATH. Information should be carefully supplied. Any word should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56769 E 56769

CERTIFICATE OF DEATH.

Registered No. 57

1-PLACE OF DEATH

City of BALTIMORE: (No. 705 Dolphin St. 4-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Nichols

(a) Residence No. 705 Dolphin St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Nichols

6-DATE OF BIRTH (month, day and year) 1875

7-AGE, 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Cambridge Md.

PARENTS.

10-NAME OF FATHER, Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Tubman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Chas. Nicholas

(Address) 705 Dolphin St.

15- Filed 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 30, 1930

17- I HEREBY CERTIFY, That I attended deceased from 4-24, 19.30 to 4-30, 19.30 that I last saw her alive on 4-30, 19.30 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C M Lawrence M. D.

, 1930 (Address) 1232 Hoshen St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cambridge Md DATE OF BURIAL 5-3 1930

20-UNDERTAKER Russell T Greenley ADDRESS 578 Wilkens Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 56770 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56770

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 22 Poppleton N. ST. 70-69 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Gill

(a) RESIDENCE NO. 221 Poppleton N. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 12, 1910

7 AGE Years 19 Months 5 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic servant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER Elizabeth Selby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Elizabeth Gill (Address) 221 N. Poppleton

15 Filed 5-2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1930

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1930, to April 30, 1930

that I last saw her alive on April 30, 1930,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D. Revell M.D.

May 1 1930 (Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem DATE OF BURIAL 5-4 1930

20 UNDERTAKER Jas. M. Skinner ADDRESS 1625 E. Fraser

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56771

E 56771

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

2—FULL NAME Clarence Willis Gosnell

(a) RESIDENCE NO. Granite, Maryland ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estelly Gosnell

6 DATE OF BIRTH (month, day, and year) May 8 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Self 075

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Edmond Gosnell

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Margrit Nicodemus

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Florence Gosnell Jr

(Address) Granite Md

15 Filed 2-1930 C. HAMPSON JONES, M. D., Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1 28th, 1930, to May 2nd, 1930, that I last saw him alive on May 2nd, 1930 and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis General

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism.

Angina Pectoris. (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs.

(Signed) W. H. Varney M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olive

DATE OF BURIAL 5/5 1930

20 UNDERTAKER Keen & Son

ADDRESS Sykesville Md

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

235-4 E 56772 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 56772

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 16-67 WARD)

2—FULL NAME Tom Skaves

(a) RESIDENCE NO. 762 Poplar Grove ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectioner 019

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Greece

PARENTS

10 NAME OF FATHER Petro Skaves

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Greece

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 FILED 2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1-1930

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1930, to May 1, 1930, that I last saw h.im alive on May 1, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Parotid Gland
Recurrent
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-12-30

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) C. D. Bregy, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 3 1930
20 UNDERTAKER George L. Schmidt	ADDRESS 401 Fredk. Ave.

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 56773 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56773

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 1951 WARD

REGISTERED NO. 1951

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Francis Gosnell

(a) RESIDENCE NO. 430 Fawcett ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4/4 yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 17, 1930.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. F. Gosnell

11 BIRTHPLACE OF FATHER (city or town) Balt. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Viola Harwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Geo. F. Gosnell (Address) 430 Fawcett

15 Filed MAY 3 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 30

17 I HEREBY CERTIFY, That I attended deceased from May 1 (GAR), 1930, to May 1 (11 30 PM) 1930, that I last saw him alive on May 1, 1930, and that death occurred, on the date stated above, at 11 30 P m. (Daylight Saving)

The CAUSE OF DEATH* was as follows: Congenital malformation of bile duct (Jaundice Neonatorum)

(duration) yrs. mos 1 3 ds.

CONTRIBUTORY (Secondary) Hemorrhage from umbilicus (duration) yrs. mos. 8 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) W. T. Lufford Jr., M. D.

May 1, 1930 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cem. Hamsted. DATE OF BURIAL May 3, 1930

20 UNDERTAKER L. Hall Dowie ADDRESS 330 E. Fawcett St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 56774

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 341 East 28th St. (Ward) 12-30

2-FULL NAME Grace Viola Lotte

(a) RESIDENCE No. 341 East 28th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur A. Lotte

6 DATE OF BIRTH (month, day, and year) Sept 30-1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Tenn

PARENTS

10 NAME OF FATHER George A. Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Susan Franklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lynchburg Va

14 Informant Arthur A. Lotte

(Address) 341 East 28th Street

15 Filed ....., 19 .... Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1930, to May 6, 1930, that I last saw h.. alive on May 1, 1930, and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Chronic Pass. Congestion of Liver

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Henry B. Thiess, M. D.

5/2, 1930 (Address) 2504 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Virginia

DATE OF BURIAL May 3 1930

20 UNDERTAKER William Cook

ADDRESS 217 S. 1st and 3rd

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—50C Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56775

CERTIFICATE OF DEATH.

VE 56775

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 822 N. Spring St. 10-13 (WARD)

2-FULL NAME Frank Quickley

(a) RESIDENCE NO. 822 N Spring ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	Col	widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Fannie Quickley

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
46	47	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O H O

(c) Name of employer Chas Hild

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Issac Quickley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary N. Means

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Lydia Matthews

(Address) 822 N Spring St

15 Filed MAY 3-1930 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 30 1930

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1930, to April 30, 1930, that I last saw h[illegible] alive on April 30, 1930, and that death occurred, on the date stated above, at 5 10 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Findings

(Signed) C. B. Le Compte, M. D.

, 19 (Address) 1113 N Chowlens St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park National Cemetery DATE OF BURIAL May 3 1930

20 UNDERTAKER Franklin W Seitz ADDRESS 709 W 33rd St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC[illegible] TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56776

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 146 ✓ E 56776

1—PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 4-30 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christine Engel

(a) RESIDENCE NO. Woodlawn Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Clarence Engel

6 DATE OF BIRTH (month, day, and year) 5/2/06

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home 37

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo Dertz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Ruppla

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Clarence Engel

(Address 1 St Lukes Lane Woodlawn)

15 Filed 3-1930 19 C. HAMPSON JONES, M. D. Registrar

By Post

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2-1930

17 I HEREBY CERTIFY, That I attended deceased from May 1 - 1930, to May 2 - 1930, that I last saw h alive on May 2 - 1930 and that death occurred, on the date stated above, at 5:35 P. M.

The CAUSE OF DEATH* was as follows:

Peritonitis (Twelve days ago)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home of patient

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms + Physical signs

(Signed) M. C. Porterfield, M. D.

19 (Address University Hospital)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interment

20 UNDERTAKER Wm Cook

DATE OF BURIAL 5/6 1930

ADDRESS 1217 Hollins St

Spec.—8-16-29—L. F. S.—100 Bks.

262320
E 56777

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 56777

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 12-50 WARD)

2—FULL NAME Perling Esch

(a) RESIDENCE NO. 200 E 22nd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Edna Esch.

6 DATE OF BIRTH (month, day, and year) Jan 6 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
57	53	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mailing Division Clerk P.O. Office

(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Post Office

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.
(State or country)

PARENTS

10 NAME OF FATHER Michael Esch.

11 BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Schofield.

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-1-1930

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to May 1, 1930, that I last saw h.im alive on May 1st, 1930 and that death occurred, on the date stated above, at 9.45 p m.

The CAUSE OF DEATH was as follows:

Carcinoma of Larynx - 2 yrs.

(duration) 2 yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary) Emphysema

(duration) ... yrs. ... mos. 8 ds.

18 Where was disease contracted if not at place of death? Johns Hopkins Hosp.

Did an operation precede death? Yes Date of April 25th 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) James Bordley 3rd, M.D.

5-2, 1930 (Address) 1211 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL May 5 1930

20 UNDERTAKER August Pasek

ADDRESS 2406 Eastland Ave

C. HANSON JONES, M.D.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56778

CERTIFICATE OF DEATH

E 56778

74-001

77-30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 645 Portland St. Ward)

2-FULL NAME Egnacas Philiposki

(a) RESIDENCE NO. 645 Portland St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Veronica Philiposki

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lithuania

PARENTS

10 NAME OF FATHER Kazmer Philiposki

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Anna Jenkauskas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Mrs. V. Philiposki
(Address) 645 Portland St

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D.

5/3, 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL May 5 1930

20 UNDERTAKER John Cubbinerus

ADDRESS 4235 Pen

1930

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56779

CERTIFICATE OF DEATH

E 56779

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4818 Kenwick Road St. 4-25 Ward)

2-FULL NAME Emma Hunters

(a) RESIDENCE NO. 622 N. Saratoga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	Col.	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Hunters

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) C. E. Douglas
(c) Name of employer 4818 Kenwick Road

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Richard Green
(Address) 612 Monument St

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis
Heart Disease
Years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) John Mowlee, M. D.

5-2, 1930 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-3 1930
20 UNDERTAKER	ADDRESS
Daniel Easton	916 Eutaw

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 56780 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56780

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 16-23

CITY OF BALTIMORE: (NO. ..... ST. ..... (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Brown

(a) RESIDENCE NO. 802 Stockton st. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Brown

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) ..... (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Goodman

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lottie Locket

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Maryland

14 Informant Hospital Records
(Address) C. HAMPSON JONES, M. D.

15 Filed MAY 3 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 19 ..., 19 30, to May 1 ..., 19 30,
that I last saw her alive on May 1 ..., 19 30,
and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) Unknown yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Glenn Jr, M. D.

5-1, 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lucky Dawn — DATE OF BURIAL 5-3-1930

20 UNDERTAKER Lemuel Evans — ADDRESS 916 Pa Ave

IMPORTANT. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56781

E 56781

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 Ellsworth ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian L. Walker

(a) RESIDENCE NO. 1707 Ellsworth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10	11	26 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Sam Walker

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Amanda J. Holbrook

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Sam Walker (Address) 1707 Ellsworth

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/2/30

17 I HEREBY CERTIFY, That I attended deceased from 5/1, 19 30, to 5/2/30, 19 30, that I last saw h W alive on 5/1, 19 30 and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. H. Gantz, M. D.

5/3, 19 30 (Address) 1409 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balt. Calvary — DATE OF BURIAL May 3 1930

20 UNDERTAKER Wm. H. G. Elliott — ADDRESS 1725 Pennsylvania Ave

Important. See instructions on back of certificates.

C. HANSON JONES

Cor.—10-10-29—A Co.—100 Bks.

E 56782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

$2 ✓ E 56782

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1121 S Hechsure 1-1 Ward)

2-FULL NAME Charles W. Thomas

(a) RESIDENCE NO. 1121 S Hechsure Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male.	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Thomas

6 DATE OF BIRTH (month, day, and year) December 24 1886

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
43.	4	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stationary Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Gunther Brewery

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry thomas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Laura Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Fredrick thomas Jr
(Address) 3020 E Eager St

15 Filed ..., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 — 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Paralysis

Cor'n

(duration) ..yrs. ..mos. ..da.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ..yrs. ..mos. 1 da.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? May 2 1930

What confirmed diagnosis? Histology

(Signed) J. C. Blades, M. D.

, 19 (Address) 1436 Berry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	May 5 1930
20 UNDERTAKER	ADDRESS
Wendell J Leppel	300 S Eden St

MAY 5 - 1930 C. HAROLD JONES, M. D. Registrar

Per

Instructions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56783

E 56790

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Balto City Hospls.

CITY OF BALTIMORE: (No. Balto Md ST., 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Stoller

(a) RESIDENCE No. 1425 Duker Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lulu Stoller

6 DATE OF BIRTH (month, day, and year) 1-6-55

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Watchman 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Peter Stoller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records City Hospls

(Address) Balto City Hospls

15 Filed 3-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30-30

17 I HEREBY CERTIFY, That I attended deceased from 3-26-, 1930, to 4-30-, 1930

that I last saw him alive on 4-30-, 1930

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH was as follows:

Myocardial Failure

Advanced Arterio

Sclerosis

(duration) yrs. mos ds

CONTRIBUTORY (Secondary) Senile Psychosis Paranoid type

Deterioration (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

5/1, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 5/3/30, 19

20 UNDERTAKER Mary F. Tuttle

ADDRESS 122 Hanover

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 56784 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56784

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital ST. 4-7 WARD)

CITY OF BALTIMORE: (NO. ST., WARD (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victor Dennison

(a) RESIDENCE NO. Hyndman Pa. ST., WARD (If non-resident give city or town and State)

(Usual place of above)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Josephine Dennison Sept 1882

6 DATE OF BIRTH (month, day, and year) July 4, 1882.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Fielding Dennison

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va.

12 MAIDEN NAME OF MOTHER McLean

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Hospital Records (Address)

15 Filed 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-3-1930

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1930, to May 2, 1930, that I last saw him alive on May 2, 1930, and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Larynx

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-29-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyko, M. D.

5/2, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hyndman Pa. DATE OF BURIAL 5-3 1930

UNDERTAKER Bernard C Harle ADDRESS 1000 Race St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56785

CERTIFICATE OF DEATH

REGISTERED NO. 91 E 56785

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Carroll

(a) RESIDENCE NO. Preston + Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Conley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Conley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor

(Address) Preston + Valley St

15 Filed MAY 3 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to May 2, 1930, that I last saw her alive on May 2, 1930 and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cerebral hemorrhage (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial cutting (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wirth, M. D.

5/3, 1930 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL May 5, 1930

ADDRESS

20 UNDERTAKER Rita Wiedefeld 914 Fremont Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 56786 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56786

CERTIFICATE OF DEATH. 90

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1213 N. Gay Street (WARD) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha M. Wallman

(a) RESIDENCE. No. 1213 N. Gay Street St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Wallman

6 DATE OF BIRTH (month, day, and year) June 16, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) York, Pa.

PARENTS

10 NAME OF FATHER William Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country) York, Pa.

12 MAIDEN NAME OF MOTHER Mary Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York, Pa.

14 Informant Charles A. Wallman

(Address) 1213 N. Gay Street

15 Filed 3 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1930, to May 2, 1930, that I last saw her alive on May 2nd, 1930, and that death occurred, on the date stated above, at 9.15 a.m. Standard time.

The CAUSE OF DEATH* was as follows:

Angina pectoris Few hours — (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. M. Lamebaker, M. D.

, 19 (Address) 2740 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick A. Lotz — DATE OF BURIAL 5/5/30

20 UNDERTAKER London Park, — ADDRESS 1200 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56787

61-E 56787

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 703 Melville ave St. 9-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Son of Vernon & Mary Barley

(a) Residence No. 703 Melville ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Sgl

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lyer

6-DATE OF BIRTH (month, day and year) May. 2-30

7-AGE. Inf yrs. mos. ds. If LESS than 1 day, 1 hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md

PARENTS.

10-NAME OF FATHER, Vernon Barley

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Fockhart

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md

14- (Informant) Vernon Barley

(Address) 703 Melville Ave

15- Filed ..... 193.. Registrar.

C. HAMPSON JONES, M. D.

3 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 2- 30

17- I HEREBY CERTIFY, That I attended deceased from May 2, 1930 to May 2, 1930

that I last saw h[illegible] alive on May 2 1930,

and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C L Long M. D.

5/3 1930 (Address) 2711 Conlon

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary cem | DATE OF BURIAL, May 3, 1930

20-UNDERTAKER, John M Deber | ADDRESS 401 S. Chester St

All plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—109 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56788 | CERTIFICATE OF DEATH | E 56788

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 6-9 Ward)

2-FULL NAME Moses Brown

(a) RESIDENCE NO. 117 N Bond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	23			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) York Co
(State or country) Pa

PARENTS

10 NAME OF FATHER Moses Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Eliza Patterson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Melvina Radcliffe
(Address) 117 N Bond St

15 Filed 19 C. THAMPSON JONES M. D. Registrar

1930 No.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said decrasrd came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Gross Findings

(Signed) C. Chas. Grady, M. D.

19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pat[illegible] Md	5-3-1930
20 UNDERTAKER	ADDRESS
Jas. Wm. Skinner	1625 E. Madison St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56789 E 56739

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH Bd. Gen Hosp

CITY OF BALTIMORE: (Ward) 916 St.

2-FULL NAME James D. Dougherty

(a) RESIDENCE NO. 1211 E. Eddie St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Jo. D. Dougherty

6 DATE OF BIRTH (month, day and year) March 31st 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) G.B.S. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md.

PARENTS

10 NAME OF FATHER John C. Dougherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Virginia Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt.

14 Informant (Address) Harper Rest Home

15 Filed MAY 3 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930 to May 1, 1930, that I last saw h[illegible] alive on May 1, 1930, and that death occurred, on the date stated above, at 9 28 P. M. S.T.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Perforation & Shock

(duration) yrs. mos. 2 hrs

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno G Hampson, M. D.

1930 (Address) Harper Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 5-5-1930

20 UNDERTAKER E. J. Fanning 1 Dm-19386. Lafayette

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56790

CERTIFICATE OF DEATH

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No.) 1000 Caton Ave ST. WARD 25-72

REGISTERED NO. 74001 56790

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Ray

(a) RESIDENCE NO. Main St Elkton City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 21 - 1857

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	73	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elkton City Maryland

PARENTS

10 NAME OF FATHER John D Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary E Keeble

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Jenkins Memorial Hosp 1000 Caton Ave

15 Filed MAY 4 - 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1930, to May 2, 1930, that I last saw him alive on 5/2, 1930, and that death occurred, on the date stated above, at 8:35 P. m.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Dennis M. D.

5/3/30 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Elkton City Md

DATE OF BURIAL 5/6/30

20 UNDERTAKER Harry A Witzke

ADDRESS 4101 Edmondson ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

56791

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56791

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 48 S. Fulton Ave. 20-28 WARD)

2-FULL NAME William J. Sabesky

(a) RESIDENCE NO. 48 S. Fulton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 10 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3, 1910.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	10		

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Blue Print Dept.

(c) Name of employer Bartlett-Hayward Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Adolph Sabesky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER May Mazal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Watson A. Sabesky

(Address) 48 S. Fulton Ave.

15 Filed 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1930, to May 2, 1930,

that I last saw him alive on May 2, 1930,

and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary & [redacted] Laryngeal Tuberculosis

(duration) About 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Harry G. Shubert M. D.

4/3/1930 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem.

DATE OF BURIAL 4/5/30 19

20 UNDERTAKER Harry A. Weitzke, 4101 ADDRESS Edmondson Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56792

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X

129 E 56792

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 7-13 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob H Goldstein

(a) RESIDENCE NO. 1004 Reisterstown Road ST., Pikesville Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Sarah

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Goldstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Hannah Frieda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Sarah Goldstein

(Address) 1004 Reisterstown Rd Pikesville Md

15 Filed MAY 4 1930 19 HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1930, to May 3, 1930,

that I last saw him alive on May 3, 1930,

and that death occurred, on the date stated above, at 7.25 m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

Hypertension

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam - Autopsy Sinai Hospital

(Signed) A. A. Silver M.D.

5/3, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd

DATE OF BURIAL May 4 1930

ADDRESS 1127 E Balto St

20 UNDERTAKER Sol Levinson & Bro

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56793 90 ✓ E 56793

REGISTERED NO.

1-PLACE OF DEATH Lewisdale

CITY OF BALTIMORE: No. Belvedere & Greenspring ST. 47-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida Sacks

(a) RESIDENCE NO. Lewisdale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Isaac

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE: Years 75 | Months — | Days — | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Edmund Hebrew Sinai Hospital

(Address) Belvedere & Greenspring

MAY 4 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to May 2, 1930, that I last saw her alive on May 2, 1930, and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Hemiplegia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Edmund Hebrew, M. D.

5/2/1930 (Address) Lewisdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

20 UNDERTAKER A. J. Simson & Bro

DATE OF BURIAL 5/4 1930

ADDRESS 1127 E. Balto st

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56794

CERTIFICATE OF DEATH

E 56794

REGISTERED NO. 10-901 15-56

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., (WARD) 15-56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Kahn

(a) RESIDENCE NO. 2922 Violet Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Chas Kahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Pa.

12 MAIDEN NAME OF MOTHER Margaret Kahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Chas Kahn

(Address) 2922 Violet Ave

15 Filed ....., 19.... Registrar

5-4-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1930

17 I HEREBY CERTIFY That I attended deceased from May 3, 1930, to May 3, 1930, that I last saw her alive on May 3, 1930, and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated Date of May 3, 1930

Was there an autopsy? No

What test confirmed diagnosis Clinical

(Signed) Myron G. Tull, M.D.

5/4, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, REMOVAL	CREMATION OR RE-	DATE OF BURIAL
Hebrew Northern Cem.		5-4-1930

20 UNDERTAKER Jacob Lewis, 1439 E Balto

ADDRESS

Spec.—1-30—M. & T.—250 Blks

E 56795 HEALTH DEPARTMENT—CITY OF BALTIMORE 100 E 56795

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hosp. (ST.) 12-44 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Selden

(a) RESIDENCE NO. 3405 Greenway Balto Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Stork Selden

6 DATE OF BIRTH (month, day, and year) Jan 5. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	3	22 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector B&O R R

(b) General nature of industry, business, or establishment in which employed (or employer) 0 13

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cincinnati Ohio

PARENTS

10 NAME OF FATHER Charles Selden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Troy N.Y.

12 MAIDEN NAME OF MOTHER Hester Gillingham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alexandria Va

14 Informant Miss Lotta Selden
(Address) Severn Apts

15 Filed C. HAMPTON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1930, to May 2, 1930,

that I last saw him alive on May 1, 1930,

and that death occurred, on the date stated above, at 12 40 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 1 yrs. ? mos ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis W Gluck, M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL May 5 1930

20 UNDERTAKER Guy O. Mitchell & Sons 1900 — ADDRESS Eutaw Place

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56796

CERTIFICATE OF DEATH.

E 56796

REGISTERED NO. 32

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (NO. ..... ST. 3400 (WARD) .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel W. Hopper

(a) RESIDENCE NO. Tudor Hall Apts. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances L. Hopper

6 DATE OF BIRTH (month, day, and year) Oct 10. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance

(b) General nature of industry, business, or establishment in which employed (or employer) 12

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER S. W. T. Hopper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emeline Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Augustine M. Hopper (Address) 39 Broadway

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2/30

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to May 2, 1930, that I last saw him alive on May 2, 1930, and that death occurred, on the date stated above, at 7.45 m. Daylight time.

The CAUSE OF DEATH* was as follows:

Benign Paroxysmal hypertrophy

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? Home apr. 1, 1930

Did an operation precede death? yes Date of apr. 22, 1930

Was there an autopsy? no

What test confirmed diagnosis? Ur. Chemistry

(Signed) Richard T. Shackelford, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL May 5 1930

20 UNDERTAKER Thomas Price — ADDRESS 1900 Eastern Ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 56797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 56797

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2313 Harlem Ave. ST. 16-69 (WARD)

2-FULL NAME Bettie Drummond Ward

(a) RESIDENCE NO. 2313 Harlem Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George F. Ward

6 DATE OF BIRTH (month, day, and year) Jan. 2, 1849

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	81	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Ezekiel Bloxsom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Susan Drummond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant G. Frank Ward
(Address) 3603 Springdale Ave.

15 Filed May 4 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2/1930

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1930, to May 2, 1930, that I last saw her alive on May 2, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Intestinal asphyxia

Cutaneous sclerosis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) A. R. Lucas, M. D.

, 19 (Address) 3921 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL May 5, 1930

20 UNDERTAKER John C. Mitchell & Sons Malcolm B. Mitchell

ADDRESS 900 Eutaw Pl

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56798

E 56798

CERTIFICATE OF DEATH.

57

REGISTERED NO. E 56798

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 W. University Pky ST. 12-49 WARD)

2-FULL NAME Katherine Rawlings Marsden

(a) RESIDENCE No. 100 W. University Parkway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles T. Marsden

6 DATE OF BIRTH (month, day, and year) Mar. 22, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Joshua S. Rawlings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co., Md.

12 MAIDEN NAME OF MOTHER Margaret Snyder

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Charles T. Marsden (Address) 100 W. University Parkway

15 Filed MAY 4 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2/30

17 I HEREBY CERTIFY, That I attended deceased from May, 1929, to May 2, 1930, that I last saw h[illegible] alive on May 2, 1930, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Metrol. Insufficiency

Diabetes Mellitus

(duration) 1 yrs mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) H. N. Bradley, M. D.

, 19 (Address) 1403 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baldwin Anne Arundel Co., Md.

DATE OF BURIAL May 6, 1930

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

Milton B. Mitchell

HOW IS very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56799 | CERTIFICATE OF DEATH. | 129 E 56799

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 715 St. Paul St. (ST.) 11-15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George T. Gambrill

(a) RESIDENCE NO. 715 St. Paul St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret J. Smith

6 DATE OF BIRTH (month, day, and year) Jan. 28, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Richard Gambrill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Iglehart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Florence M. Gambrill (Address) 715 St. Paul St.

15 Filed MAY 4 1930. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 2. 30.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929, to May 2, 1930, that I last saw h.. alive on May 2, 1930, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro-Sclerosis

(duration) 5 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James C Clark, M. D.

5/2, 1930. (Address) La Fonte Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: May 5, 1930

20 UNDERTAKER: John O. Mitchell & Sons, 1900 Eutaw Pl. — ADDRESS

Mahlon B. Mitchell

Spec.—1-30—M. & T.—250 Blks.

E 56800 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 56800

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 1420 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Smith

(a) RESIDENCE NO. St Vincent Infant Asylum ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	—

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER David E Daly

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Dimattei

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Margaret Dimattei

(Address) 1701 Division

15 Filed 5-4-1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-3-30

17 I HEREBY CERTIFY, That I attended deceased from 3-28, 1930, to 5-3, 1930, that I last saw h[illegible] alive on 5-3, 1930, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Geyko M. D.

5/3, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL 5/4, 1930

20 UNDERTAKER Jno J Fahey Sons — ADDRESS 218 Eight St

ATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Dunn

E 56801

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 56801

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St., 17-26 W.)

2-FULL NAME Wm R. Dunn

(a) RESIDENCE NO. 128 W. Franklin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. da:

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Dunn

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Wilmington Del
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Carrie Dunn Wife
(Address) 128 Franklin St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Bronchial Pneumonia 2 days ago

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Riley Lewis, M. D.

May 3 1930 (Address) 639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL May 5 1930

20 UNDERTAKER Samuel S. Hemsley

ADDRESS 501 Bdle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 E 56802

E 56802

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2121 Oak St.) 12-51 (Ward)

2-FULL NAME Mary Joyner

(a) RESIDENCE NO. 2121 Oak St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 28 1915

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	15	3	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) School girl
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Columbia S. C.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Joyner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S. C.

14 Informant Sarah Boylan
(Address) 2121 Oak St.

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, aforesaid find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Dilatation of Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

5/2, 1930 (Address) 3632 Reisterstown Rd

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem

DATE OF BURIAL 5/4 1930

20 UNDERTAKER Samuel F. Hinkley

ADDRESS [illegible]

Have entries carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-36—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56803

143-003

E 56803

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hosp. St., 27-37 Ward)

2-FULL NAME Josephine Rzepka

(a) RESIDENCE NO. 1604 Malvern St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Rzepka

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 40; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Joseph Rzegnewski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frank Rzepka

(Address): 1604 Malvern St.

15 Filed ..... 19 ..... C. HARRISON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest by Degnan (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest Degnan (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Myocardial Failure

8 mo's Pregnant

(Duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) ... yrs. ... mos. ... ds.

May (Signed) Geo Glades M. D.

(Coroner)

5/30 (Address) 1436 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. Date of Burial: May 5 1930

20 UNDERTAKER: Stephen J. Kraft Sons 1000 E. Lexington

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 180 M. & T.—250 M-34.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56804

99-92

E 56804

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 S. Highland Ave. ST. 26-1 WARD)

2-FULL NAME Andrew Neundorfer.

(a) RESIDENCE NO. 926 S. Highland Ave. ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of The Late Margaret Neundorfer

6 DATE OF BIRTH (month, day, and year) Jan. 22 nd. 1 863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Christina Lindenberger (Address) 926 S. Highland Ave.

15 Filed May 4 - 1930 HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2/30

17 I HEREBY CERTIFY, That I attended deceased from February, 1930, to May 2, 1930,

that I last saw him alive on April 24, 1930,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) yrs. 3 mos da.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. P. Bronushas, M. D.

5-3-30 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery — DATE OF BURIAL: May 5th 1930

UNDERTAKER: Lilly & Zeiler Inc. 403 — ADDRESS: S. Wolfe St.

Spec.—1-10-21—M&T—1500 Bks.

E 56805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 56805

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital 10 WARD)

2-FULL NAME Mrs Lena Miller

(a) RESIDENCE NO. 2424 Foster Ave ST., 26 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Miller

6 DATE OF BIRTH (month, day, and year): Aug 24 th. 1888

7 AGE — Years: 41 — Months: 8 — Days: 8 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Charles Roth.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary Hammer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Louis Miller. (Address): 709 S. East Ave.

15 Filed ..... 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2 1930

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1930, to May 2, 1930

that I last saw her alive on 5-2, 1930

and that death occurred, on the date stated above, at 6.05 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Subdiaphragmatic abscess (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of .....

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) ..... M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: May 6/30

20 UNDERTAKER: Lilly & Zeiler Inc.

ADDRESS: 403 S. Wolfe St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56806 129 E 56806

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 N Chester ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elenora S. Schmidt

(a) RESIDENCE NO. 1802 N Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred (40) mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/25/1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Frederick W. Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Boeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Conrad (Address) 1802 N Chester st

15 Filed 4-1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/2/1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 7, 1930, to May 2, 1930, that I last saw h[illegible] alive on May 2, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Cardiac Decompensation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis and Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

(Address) 4702 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 5/6/1930

20 UNDERTAKER Robt J Turner

ADDRESS 1442 N Broadway

Spec.—1-30—M. & T.—250 Blks.

Registration No. 5380 E 56807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56807

1-PLACE OF DEATH Mercy Hospital 13-54 24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No.) ST. WARD

2-FULL NAME Mrs. May St. John.

(a) RESIDENCE No. 2842 Woodbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 26 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Modiste

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm C.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Carlisle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md ?

14 Informant Hospital Records

(Address)

Filed 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-3-30

17 I HEREBY CERTIFY, That I attended deceased from 5. 1. 1930, to 5. 3. 1930, that I last saw h[illegible] alive on 5. 3. 1930, and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH* was as follows:

Meningococcus Meningitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab

(Signed) J. Zeyher M. D.

5. 3. 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL May 5 1930

UNDERTAKER [illegible]

ADDRESS 1329 Eutaw Pl

FRONT Very Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 56808

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 E 56808

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 9-18 Ward)

2-FULL NAME Robert Flower

(a) RESIDENCE NO. 1209 E. North Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jennie A. Flower

6 DATE OF BIRTH (month, day, and year) Apr 24/1850

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	80	0	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Builder
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co., Md.
(State or country)

PARENTS

10 NAME OF FATHER Flower

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Packer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Jennie A. Flower
(Address) 1209 E. North Ave

15 Filed ..., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia- 2nd degree burns - body & extremities. Clothing caught fire while burning papers etc in furnace; Apr 30/30. in his home. yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

5/3/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bryanville Penna	5/5 1930
20 UNDERTAKER Coale	ADDRESS 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56809

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56809

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 602 Chapelgate Lane ST. ..... WARD 20-W

2-FULL NAME Alice Robertson Embank

(a) RESIDENCE NO. 602 Chapelgate Lane ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Thomas J Embank

6 DATE OF BIRTH (month, day, and year): Feb 17 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	2	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 637
(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Ga

PARENTS
10 NAME OF FATHER: John T Robinson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Margaret E White
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Harry R Embank
(Address) 3337 Woodland Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2. 1930

17 I HEREBY CERTIFY, That I attended deceased from yrs. 28 '28, to May 3rd 1930, that I last saw h[er] alive on May 2nd 1930, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:
Encepelas 2d
Coup
(duration) ..... yrs. ..... mos ..... da.
CONTRIBUTORY (Secondary) General Debility from
Chronic Art (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J M P Byerly, M. D.
, 19 (Address) 904 6 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (Fill reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lancaster Lebanon Cemetery Virginia
DATE OF BURIAL: 5/5/1930

20 UNDERTAKER: Wm Cook
ADDRESS 1217 E Fayette St

FOR IMPORTANT INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-30—M. & T.—250 Bks

Dr Rutzel 2221 W Fulton Ave Lot 3630

E 56810 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56810

90

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2404 W Franklin ST. 20-69 (WARD)

2-FULL NAME Denbah L. Knight

(a) RESIDENCE NO. 2404 W Franklin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William C Knight

6 DATE OF BIRTH (month, day, and year): Mar. 4 1884

7 AGE: Years 46 | Months 2 | Days 29 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer): 0
(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Steven L Hurley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Fannie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Wm C Knight Sr
(Address) 2404 W Franklin St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15th, 1930, to May 3rd, 1930, that I last saw her alive on April 5th, 1930, and that death occurred, on the date stated above, at 5:00 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) ..... yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Usual Routine

(Signed) Ebert G. Reitzel M. D.

5/3, 1930 (Address) 2221 W. Fulton Av. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 5/8 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

FOR IS very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

Dr Sellner
4900 Belair Road

E 56811

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 001 E 56811

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 East Oliver St. 8-17 WARD)

2-FULL NAME George H. Deetjen

(a) RESIDENCE No. 1808 East Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 9 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Store

(b) General nature of industry, business, or establishment in which employed (or employer) Business

(c) Name of employer Himself. 045

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Mark Deetjen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Betty Bachen Aug

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Lena M. Deetjen
(Address) 1808 East Oliver Street

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1930

17 I HEREBY CERTIFY, That I attended deceased from April 26th 30 to May 3 1930
that I last saw h live on May 2nd 1930
and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) yrs. 1 mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Sellner M. D.
19 30 Address 4900 Belair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery

DATE OF BURIAL May 5 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

FROM IF very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56812

CERTIFICATE OF DEATH

101-001

E 56812

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 402 W Hoffman St. 11-24 (Ward)

2-FULL NAME Robt Smith Jr

(a) RESIDENCE NO. 402 W Hoffman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie

6 DATE OF BIRTH (month, day, and year) Aug 1-1892

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	37	9	1	

8 OCCUPATION OF DEACESED
(a) Trade, profession or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer) 013
(c) Name of employer Smith Md.

9 BIRTHPLACE (city or town) Balt Md.
(State or country)

PARENTS

10 NAME OF FATHER Robt Smith

11 BIRTHPLACE OF FATHER (city or town) Balt Md.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Butler

13 BIRTHPLACE OF MOTHER (city or town) Balt Md.
(State or country)

14 Informant Rose Lee
(Address) 912 Linden Ave

15 Filed AUG 4 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) ..... M. D.

May 3rd 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	5-5 1930
20 UNDERTAKER Dent & Eastes	ADDRESS 974 Pacific

Spec.—2-29-28—L. F. S.—500 Bks.

E 56813

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56813

CERTIFICATE OF DEATH

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 N Hilldale ST. 8-17 WARD)

2—FULL NAME Jane Singleton

(a) RESIDENCE NO. 1516 N Hilldale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Married

6a If married, widowed, or divorced HUSBAND of (or WIFE of) Jane Singleton

6 DATE OF BIRTH (month, day, and year) Dec 1-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. Carolina

PARENTS

10 NAME OF FATHER Wm Singleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) S C.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Jane Singleton
(Address) 1516 N Hilldale St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov , 1929, to May 2, 1930, that I last saw h[illegible] alive on April 1, 1930 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis

Hypertension and Generalized Anasarca (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R E Young, M. D.

5/3, 1930 (Address) 1429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 5-6-1930

20 UNDERTAKER Frank W. Leitz — ADDRESS 709 W 33 St

Binder ✓

Spec.—1-10-21—M&T—1500 Blks.

E 56814 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56814

CERTIFICATE OF DEATH. 90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. General Hospital ST. 12-44 WARD

2-FULL NAME Miss Elizabeth Binder

(a) RESIDENCE NO. 536 N. University Parkway ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept. 5, 1855.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Simon Binder

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Annis Fuchs

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Hospital records
(Address)

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1930

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1930, to May 3, 1930, that I last saw her alive on May 3, 1930, and that death occurred, on the date stated above, at 5:35 a.m. S.T.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 5 yrs. (?) mos ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ✓ yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) ..... M.D.

19 ..... Address .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dorsey-Howard Co. Md	May 5 1930
21 UNDERTAKER Wm. J. McKnew & Sons	ADDRESS North & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56815 100-0? 56815

CERTIFICATE OF DEATH

1—PLACE OF DEATH Home for Incurables. REGISTERED NO. 13-52

CITY OF BALTIMORE: (No. Home for Incurables ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME (Mrs.) Martha Bott

(a) RESIDENCE NO. Home for Incurables ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 ~~Single, Married, Widowed, or Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE~~ of Jane Bott

6 DATE OF BIRTH (month, day, and year) 1866 - July 26

7 AGE ~~Dys~~ 63 Years 1866 ~~Months July~~ 9 ~~Days 26~~ 6 If LESS than 1 day, ~~hrs.~~ or ~~min.~~

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 69

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hartford County Md.

PARENTS

10 NAME OF FATHER William Buckingham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard County, Md.

12 MAIDEN NAME OF MOTHER Mary Rollis.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard County Md.

14 Informant Mrs. Grace Buckingham (Address) Parkville, Md

15 Filed 4 - 1930 H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2. 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1930, to May 2, 1930, that I last saw her alive on May 2, 1930 and that death occurred, on the date stated above, at 8:55 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho-)

30 (duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Emphysema and cardiac failure (duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ~~No~~ Yes.

(Signed) H. S. Willis, M. D.

5/3, 1930 (Address) Med. Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Hill - York, Pa

DATE OF BURIAL May 4 1930

20 UNDERTAKER J. J. Tichenor & Sons

ADDRESS York, Pa

Spec.—1-10-21—M&T—1500 Blks.

E 56816

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56816

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Md Gen Hosp. St., 15-65 WARD)

2-FULL NAME Louis Mackert Eastman Jr.

(a) RESIDENCE NO. 2516 Queen Anne Rd. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Wid.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ May Dean Eastman

6 DATE OF BIRTH (month, day, and year) Apr. 16-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	58	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician.

(b) General nature of industry, business, or establishment in which employed (or employer) 54

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Mackert Eastman

11 BIRTHPLACE OF FATHER (city or town) Balti. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Ann Formley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Hosp. Records

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) F-2 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-14-30, 19..., to 5-2-30, 19...,

that I last saw h[im] alive on 5-2-30, 19...,

and that death occurred, on the date stated above, at 7:10 A S.T. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Congestive Heart Failure

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Donaldson M. D.

19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 5/5 1930

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 405 N. Calvert

CAUSE OF DEATH must be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMILTON JONES, M. D.

Y 4 - 1930

Spec.—2-29-28—L. F. S.—500 Blks.

E 56817

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56817

REGISTERED NO. 57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Hospital for Women ST., 5-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Lelia Estelle Markell

(a) RESIDENCE NO. 3428 Mondawmin Ave ST., Walbrook WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 8 mos. 15 ds. How long in U. S., if foreign birth 66 yrs. 8 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) ~~WIFE of~~ Edward Markell

6 DATE OF BIRTH (month, day, and year) May 15th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66 yrs	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Markell

11 BIRTHPLACE OF FATHER (city or town) Baltimore (?) (State or country) Md.

12 MAIDEN NAME OF MOTHER (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Mrs. Lelia M. Allen

(Address) 1436 N. St. N.W. Washington

15 Filed MAY 4 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4, 1930

17

I HEREBY CERTIFY, That I attended deceased from 3:00 PM May 3 1930, to 2:45 AM May 4 1930,

that I last saw h[illegible] alive on May 4th at 2:15 AM 1930

and that death occurred, on the date stated above, at 2:45 A.m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart.

(duration) 3 hours

CONTRIBUTORY (Secondary) Arteriosclerotic condition. (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam; surgery + clinical course

(Signed) [illegible] M. D.

. 19 (Address) Hospital for Women Balto.

(?) *State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Israel Mount Cemetery

DATE OF BURIAL May 6 1930

20 UNDERTAKER Stewart & Mowen

ADDRESS N. Howard

Spec.—2-29-28—L. F. S.—500 Bks.

E 56818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 56818

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Edgewood Sanatorium (WARD) 8-17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rachel Jane Swearer

(a) RESIDENCE NO. 1736 E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 5 mos. 13 ds. How long in U. S., if foreign birth 86 yrs. mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of William Swearer

6 DATE OF BIRTH (month, day, and year) Nov. 15 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Evans

11 BIRTHPLACE OF FATHER (city or town) unknown

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Evans

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country) Maryland

14 Informant Mrs. Elizabeth Hillas (Sister)

(Address) 532 Bloomfield Baltimore

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3/30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930, to May 2, 1930, that I last saw her alive on May 2, 1930, and that death occurred, on the date stated above, at 6 05 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab. findings

(Signed) D. W. Towers, M. D.

19 (Address) 1813 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL May 5 1930

20 UNDERTAKER Stewart & Company

ADDRESS Baltimore

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56819

CERTIFICATE OF DEATH.

11 E 56819

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909- Montpelier St. 19-46 WARD)

2-FULL NAME John T. Packenpaugh

(a) RESIDENCE NO. 909- Montpelier St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen O'Connor Packenpaugh

6 DATE OF BIRTH (month, day, and year) 8-31-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	46	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 063

(b) General nature of industry, business, or establishment in which employed (or employer) M. & F. & G. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Packenpaugh

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Packenpaugh

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Mrs. Helen Packenpaugh (Address) 909- Montpelier St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30-30

17 I HEREBY CERTIFY, That I attended deceased from 4-26, 1930 to 4-30, 1930.

that I last saw h. alive on 4-30, 1930.

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart (duration) ..... yrs. ..... mos. 20 Min.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Seymour Pollock, M. D.

5-1-1930 (Address) 2202 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 5/5/30 19

20 UNDERTAKER Mary T. Ruth. 1235 Harford Av.

ADDRESS

VAMC. HAROLD JAMES, M.D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56820

CERTIFICATE OF DEATH

38 E 56820

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 202 McCulloh St., 11-24 Ward)

2-FULL NAME Lee Bailey

(a) RESIDENCE No. 202 McCulloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 Color or Race Col | 5 Single, Married, Widowed or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Aug 1 1892

7 AGE Years 37 | Months 9 | Days 2 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Helper in Garage
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Henry Bailey

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Betty Robinson

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Rosa Strength
(Address) 1416 Argyle Ave

15 Filed May 9 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Error Jelut

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) ..... M. D.

May 9 1930 (Address) Boone

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jeterville, Va.

DATE OF BURIAL 5/4/1930

20 UNDERTAKER Wm. Geo. A. Holland

ADDRESS 1601 Druid Hill

Cor.—10-10-29—A Co.—100 Bks.

E 6821

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 6821

+ 74001

CERTIFICATE OF DEATH

REGISTERED NO. [redacted]

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St. 4-7 Ward)

2-FULL NAME GEORGE B. AUSTIN

(a) RESIDENCE NO. 6605 Beech Ave., Overlea St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Sarah Belle Austin

6 DATE OF BIRTH (month, day, and year) Sept. 25th, 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	67	7	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Motor Maker
(b) General nature of industry, business, or establishment in which employed (or employer) Md. Motor Works
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Austin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Sophia Wilkinson

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Md

14 Informant Sarah Belle Austin
(Address) 6605 Beech Ave. Overlea

15 Filed May 4 1930 H. HARROW JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,
Hypertension
4 yr. Arteriosclerosis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis

(Signed) H. J. Perry Carr, M. D.

May 3 1930 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 5 1930
20 UNDERTAKER Frederick Loseke & Sons	ADDRESS Fullerton

Spec.—1-30—M. & T.—250 Bks.

E 56822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56822 129

REGISTERED NO.

1-PLACE OF DEATH Southern Hosp. Home

CITY OF BALTIMORE: (No.) 12-50 ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert R Lloyd

(a) RESIDENCE NO. Southern Hosp Home ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Hannah J Lloyd

6 DATE OF BIRTH (month, day, and year): Dec 21, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Music Instructor

(b) General nature of industry, business, or establishment in which employed (or employer): 186

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Robert Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wales

12 MAIDEN NAME OF MOTHER: Ellen Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wales

14 Informant: Harry M Brooks

(Address): Delta Pa

15 Filed MAY 4 1930 HARRY JONES, M. D. Registrar

By RWK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1930, to May 4, 1930,

that I last saw h— alive on May 3, 1930,

and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows: Chron Interstitial Nephritis

(duration) more than yrs. 7 mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Koerber Jr M. D.

5-4, 1930 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Delta Pa

DATE OF BURIAL: 5/4 1930

20 UNDERTAKER: W M Cook

ADDRESS: 1217 E Pratt St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 № 56823

№ 56823

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (NO. S 15-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Payne

(a) RESIDENCE NO. 1422 N. Parrish st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Payne

6 DATE OF BIRTH (month, day, and year) 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Harshaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Elizabeth Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 Filed 1930 H. M. Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to May 1, 1930, that I last saw her alive on May 1, 1930, and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows: Cardiac Failure

outer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Jas Stevens M. D.

5-2, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Gilbert — DATE OF BURIAL May 6 1930

20 UNDERTAKER H C Engelbrecht & Son — ADDRESS Ellicott City

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56824

56824

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Olivia ST. 4-17 WARD)

2-FULL NAME Charles D. Goodwin

(a) RESIDENCE NO. Weston, W. Va. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 27th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Post Master.

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer 86

9 BIRTHPLACE (city or town) (State or country) West Va

PARENTS

10 NAME OF FATHER Samuel S. Goodwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va.

12 MAIDEN NAME OF MOTHER Malinda Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va

14 Informant Mrs Ivy Straley
(Address) 343 Mt Clare Station West Va.

15 Filed MAY 4 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-21, 1930, to 5-4, 1930, that I last saw h[illegible] alive on 5-4, 1930, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of Prostate

Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Auricular Fibrillation

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) W. B. Hendrix, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairview Cem West Va.	5/8/ 1930
20 UNDERTAKER John J. Howard & Son	ADDRESS 901 Hollins St.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56825 E 56825

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Howard A Kelly Hospital

CITY OF BALTIMORE: (No. ... St. 1470 WARD)

REGISTERED NO. ...
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry L. Adler

(a) RESIDENCE NO. 236 Park Hotel ST., ... WARD Dallas Texas
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 21 - 1880

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
50	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dentist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Lawrenceburg
(State or country) Indiana

PARENTS

10 NAME OF FATHER Louis Adler

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Ohio

12 MAIDEN NAME OF MOTHER Betty Gerstle

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Ohio

14 Informant Emma Adler Victor (sister)
(Address) 622 Richmond Ave Buffalo N.Y.

15 Filed MAY 5 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1927 to May 4 1930, that I last saw him alive on May 4 1930 and that death occurred, on the date stated above, at 12.15 (Std.)

The CAUSE OF DEATH* was as follows:

Myeloid leukemia

(duration) 10 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? blood counts

(Signed) Edmund Kelly, M. D.

May 4, 1930 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cincinnati Ohio — DATE OF BURIAL: May 5 1930

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North ave

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56826

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56826

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO. 12-50

CITY OF BALTIMORE: (No. ..... St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Melis

(a) RESIDENCE No. 414 East 31 st St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Frederick - W.

6 DATE OF BIRTH (month, day, and year) July 14, 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Germany

PARENTS

10 NAME OF FATHER Franz Meissner

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Hospital Records (Address)

15 Filed 5-5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-18, 1930, to 5-3, 1930, that I last saw him alive on 5-3, 1930, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardiovascular renal disease with hypertension

(duration) ? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Feyko, M. D.

5/3, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 5/6 1930

20 UNDERTAKER Henry W. Meyers & Son

ADDRESS 805 N. Calvert

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56827

E 56827

CERTIFICATE OF DEATH

167-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 819 W. Lombard St., 18-26 Ward)

2-FULL NAME Pijus Nareskis

(a) RESIDENCE NO. 819 W. Lombard St., Ward

(Usual place of abode) 28 (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Nareskis

6 DATE OF BIRTH (month, day, and year) 1882.

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lithuania

PARENTS

10 NAME OF FATHER Joseph Nareskis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. A. Nareskis
(Address) 819 W Lombard St

15 Filed ... 19... Registrar

5 - 1930 (C W ...)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Poisoned by C.O. Illuminating Gas.
Suicide
(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fillis M. D.

5/3, 1930. (Address) 273 E Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Londonpark Cemetery — DATE OF BURIAL: May 5 1930

20 UNDERTAKER: Charles B. Kuhnauskas — ADDRESS: 6325 Pulaski Hy

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very OF DEATH in plain terms, so that it may be properly classified.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56828

CERTIFICATE OF DEATH

90 ✓

E 56828
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. Lydia Rd St., Mansfield 14 Ward)

2-FULL NAME Chas. H Cole

(a) RESIDENCE NO. 1916 McCulloh St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elenor Cole

6 DATE OF BIRTH (month, day, and year) Oct 11th 1864

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
65	7	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lab-
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Saml. Cole

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ann Mitchell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Elenor Cole
(Address) 1916 McCulloh

15 Filed May 5 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry), find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. H Bonnette, M. D.
May 4. 1930 (Address) 3600 E Lo

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL May 6th 1930

UNDERTAKER Clemmer & Wright — ADDRESS 700 North Caroline Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56829

CERTIFICATE OF DEATH.

91-002 E 56829

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6205 Harford Rd ST 27-43 WARD)

2-FULL NAME John T. Roberts

(a) RESIDENCE NO. 6205 Harford Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lillie L. Roberts

6 DATE OF BIRTH (month, day, and year) Dec 11-1843

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
86	4	20 21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pimlico and Md

PARENTS

10 NAME OF FATHER John R. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Somerville

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Edith Young (Address) 6205 Harford Rd

15 Filed MAY 5 - 1930 by C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2/30

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1930 to May 2, 1930

that I last saw him alive on May 2, 1930

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos 7 da.

CONTRIBUTORY (Secondary) Arterio Sclerosis many years (duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Morris B Green M. D.

5/3/1930 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL 5/5 1930

20 UNDERTAKER L J Rush — ADDRESS 1405 5 ft Ave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56830

CERTIFICATE OF DEATH.

21

E 56830

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2800 Manhattan Ave. ST. 27-55 WARD)

2-FULL NAME Cordelia Louise Friez,

(a) RESIDENCE NO. 2800 Manhattan Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Julien P. Friez

6 DATE OF BIRTH (month, day, and year) May 8th. 1858

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila. Pa.

PARENTS

10 NAME OF FATHER Charles Schämpf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Matilda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Mrs. Burns Hyland (Address) 2800 Manhattan Ave.

15 Filed 5 1930 19 C. H. HELEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1930, to May 3, 1930, that I last saw h[illegible] alive on May 3, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) ....yrs. mos 11 ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Edwin S. Crager, M. D.

5/5, 1930 (Address) The Esplanade

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery.

DATE OF BURIAL May 6th 1930

20 UNDERTAKER Chas. F. Evans & Son

ADDRESS 11 W. Mt. Royal Ave

E 56834

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56834

CERTIFICATE OF DEATH.

Registered No. C 203

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 26-39 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard J. Scholz

(Residence in Baltimore: No. 3518 E. Baltimore St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: Oct 10 1908 (Month) (Day) (Year)

7-AGE: 21 yrs. 6 mos. 23 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Orange worker
(b) General nature of industry, business, or establishment in which employed (or employer): Bal. Steel

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS:

10-NAME OF FATHER: Chas. Scholz

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Mary Dulda

13-BIRTHPLACE OF MOTHER, (State or Country): Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Scholz

(Address) 3518 E Balto St

15- MAY 6 - 1930 HAMPSON JONES, M. D. Registrar.

Per ____

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 3rd (Day) 1930 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy (autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident in which he was a rider upon auto which ran into culvert on concrete culvert edge fell upon auto causing injuries

CONTRIBUTORY (Secondary) Fract Pelvis

(Duration) ....yrs. ....mos. ....ds.

(Signed) G J Fraunfelter M. D. (Coroner)

5/4/1930 (Address) 29 E Fait Elden

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 5/19/30

19-PLACE OF BURIAL OR REMOVAL: Western Cem DATE OF BURIAL, May 6th 1930

20-UNDERTAKER, Geo W Smith & Son ADDRESS 811 N Wolfe St

Geo W Smith & Son 811 N Wolfe St

Is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

56832 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 E 56832

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1330 S. Charles ST. 23-31 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie Viola Fletcher

(a) RESIDENCE NO. 1330 S. Charles St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Fletcher

6 DATE OF BIRTH (month, day, and year): Oct 24 1892

7 AGE: Years 37 | Months 6 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Edgar Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Nettie Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: John Fletcher

(Address) 1330 S. Charles St

15 Filed 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 1930

17 I HEREBY CERTIFY, That I attended deceased from May 3 1930 to May 4 1930

that I last saw her alive on May 4 1930

and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Infected Tonsils

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptomatology

(Signed) H. H. Brayshaw M. D.

19 (Address) 1328 S. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Riverton Md — DATE OF BURIAL: May 6 1930

20 UNDERTAKER: Los Foresters Dan — ADDRESS: 217 S. Pan

Spec.—12-9-25—A Co.—200 Blks.

56833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓ E 56833

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave St. 20-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Geo W. Sheridan

(a) RESIDENCE NO. Home for the Aged of the M.E. Church Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosella Sheridan

6 DATE OF BIRTH (month, day, and year): September 2 - 1863.

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	66	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired M.E. Minister

(b) General nature of industry, business, or establishment in which employed (or employer): ✓ 18

(c) Name of employer: ✓

9 BIRTHPLACE (city or town)

(State or country) Washington D.C.

PARENTS

10 NAME OF FATHER: Frederick Sheridan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER: Margaret Maher.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland.

14 Informant: Mary B. Trout.

(Address) 400 N. Fulton Ave

15 Filed MAY 5 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 3 - 1930.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1st, 1930, to May 3, 1930, that I last saw him alive on May 3, 1930, and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 1 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Nephritis Chronic.

(duration) ✓ yrs. 8 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical methods

(Signed) George C. Shannon, M. D.

5/3, 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Cemetery — Date of Burial: May 5 1930

20 UNDERTAKER: Geo J. Smith — ADDRESS: 1532 Hollins St

If the certificate is not filled out in every item, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 56834

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56834

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Jenkins Memorial Hospital ST. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus A. Hall

(a) RESIDENCE NO. Hopkins Apts #410 ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hooper Hall

6 DATE OF BIRTH (month, day, and year) June 13, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 63

Retired Proof Reader

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore American

9 BIRTHPLACE (city or town) Crisfield

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William H. Samuel Hall

11 BIRTHPLACE OF FATHER (city or town) Crisfield

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Gibson

13 BIRTHPLACE OF MOTHER (city or town) Crisfield

(State or country) Maryland

14 Informant Miss M. Susie Hall

(Address) Hopkins Apts. # 410

15 Filed ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-1, 1928. to 5-2, 1930.

that I last saw h[illegible] alive on 5-2-30, 19.....

and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner, M. D.

5/2, 1930 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 5 1930

20 UNDERTAKER Robert D Cook

ADDRESS 1003 West Baltimore St

HON. is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 56835 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56835

CERTIFICATE OF DEATH. 129 v

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2742 Alameda ST. 9th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Eddie Virginia Green

(a) RESIDENCE NO. 2742 Alameda ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Frank L. Green

6 DATE OF BIRTH (month, day, and year) April 5, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	0	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Fredrick, (State or country) Maryland

10 NAME OF FATHER George W. Keefer

11 BIRTHPLACE OF FATHER (city or town) Fedrick, (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Kimbry

13 BIRTHPLACE OF MOTHER (city or town) Fredrick, (State or country) Maryland

14 Informant Mrs Leon Gray (Address) 2742 Alameda

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1930, to May 4, 1930, that I last saw her alive on May 4, 1930, and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows

Chronic Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Chas Wm Edmonds M. D.

May 7, 1930 (Address) 2746 Alameda Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL May 7 1930

20 UNDERTAKER Lee & D Cook

ADDRESS 1003 W Balto St

66866 M&T—1500 Bks.

E 56836

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. Gen. Hosp. ST. 16-68 WARD)

2-FULL NAME Miss Ida L. Wood

(a) RESIDENCE NO. Maple St Woodlawn ST., ... WARD .....
(Usual place of abode) and 2117 Winchester St.
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 1, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~54~~	60	8	31	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fore Woman

(b) General nature of Industry, business, or establishment in which employed (or employer) Erlanger Bros. Erlanger Bros.

(c) Name of employer

9 BIRTHPLACE (city or town) Balt. (State or country) Md.

PARENTS

10 NAME OF FATHER Adam L. Wood

11 BIRTHPLACE OF FATHER (city or town) Balt, (State or country) Md.

12 MAIDEN NAME OF MOTHER C.C. Nally

13 BIRTHPLACE OF MOTHER (city or town) Balt, (State or country) Md.

14 Informant Hospital record
(Address) C. HAMPSON JONES M.D.

15 Filed C. HAMPSON JONES, M.D. Registrar

MAY 7 1930

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 4, 1930, that I last saw h[illegible] alive on May 4, 1930, and that death occurred, on the date stated above, at 5:15 p.m. S.T.

The CAUSE OF DEATH* was as follows:

Rheumatic Cardio-vascular disease

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. 7 mos. 37 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Ingeborg Thompson, M. D.

5/4/30 (Address) The Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL May 6 1930

20 UNDERTAKER Joseph L. Cook

ADDRESS 1003 West Baltimore St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56837

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56837

CERTIFICATE OF DEATH

REGISTERED NO. 78

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Bethelhem Ave. 26-37 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Mike Salaba Jr

(a) RESIDENCE NO. 1307 Bethelhem Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 3 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 2 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Mike Salaba

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mary Smith Salaba (Address) 1307 Bethelhem Ave

15 Filed MAY 5 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 3, 1930, that I last saw h alive on May 3, 1930 and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Paralysis (Birth) +
Epilepsy

(duration) 6 yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary) Status Epilepticus (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Vincent Doska, M. D.

, 19 (Address) 845 W. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Mary

DATE OF BURIAL 5/6 1930

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul St.

Spec.—1-10-21—M&T—1500 Bks.

E 56838

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56838

CERTIFICATE OF DEATH

REGISTERED NO. 29

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) St. Josephs Hospital WARD) Lakeside & Lewis Sts. Sister M. Benjamine D. of P.

2-FULL NAME Mary Beck

(a) RESIDENCE NO. St Josephs Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? 46 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 11 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	6	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Religious Nun
(b) General nature of industry, business, or establishment in which employed (or employer) Order of St. Francis
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Robert Beck
11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)
12 MAIDEN NAME OF MOTHER Mary Ruprecht
13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant (Address) Records of St. Josephs Hospital Lakeside & Lewis Sts.

15 Filed 5 1930 C. HAMPSON JONES, M. D. Registrar

Ref. RM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-3-30

17 I HEREBY CERTIFY, That I attended deceased from 7-1-29, 19 to 5-3-30, 19
that I last saw h alive on 5-3-30, 19
and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:
Essential Hypertension,
Chronic Myocarditis
& Nephritis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremia & Cardiac Dilatation (duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? Place death
Did an operation precede death? No Date of None
Was there an autopsy? No
What test confirmed diagnosis? Clinical Course

(Signed) M B Hendrix, M. D.
5/3/1930 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL May 6 1930

20 UNDERTAKER Henry Hoech Sons, Inc. — ADDRESS 1301 E Eager St

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

235884 E 56839

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

E 56839

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~JOHNS HOPKINS HOSPITAL~~ ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Douglas H Cochran

(a) RESIDENCE NO. Ambler Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helena

6 DATE OF BIRTH (month, day, and year) Nov-18-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate! 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa (State or country)

PARENTS

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town) Pa (State or country)

12 MAIDEN NAME OF MOTHER Anna Haly

13 BIRTHPLACE OF MOTHER (city or town) Pa (State or country)

14 Informant Records

(Address) ~~JOHNS HOPKINS HOSPITAL~~

15 Filed ....., 19.... Per ..... Registrar

C. HAMPSON JONES, M. D.

5-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-5-1930

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to May 5, 1930, that I last saw h~~im~~ alive on May 5, 1930 and that death occurred, on the date stated above, at 3 48 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma lung (at.)

(duration) ....yrs. ?....mos.....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs.....mos.....ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) R. Hooper Smith, M. D.

May 5 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phila. Pa.

DATE OF BURIAL May 5 1930

20 UNDERTAKER John O Mitchell & Sons

ADDRESS 1900 Euclid Place

Spec.—1-30—M. & T.—250 Blks

E 56840

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56840

CERTIFICATE OF DEATH.

74

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3021 Eastern Ave ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph Feldmann

(a) RESIDENCE NO. 3021 Eastern ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Feldmann

6 DATE OF BIRTH (month, day, and year) March 12 1874.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker. do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer owner

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wilhelm Feldmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Stemler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Pauline Feldmann (Address) 3021 Eastern ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 - 1930.

17 I HEREBY CERTIFY, That I attended deceased from April 28th, 1930, to May 2nd, 1930, that I last saw him alive on May 2nd, 1930, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage 2nd

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) 2 yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible], M. D.

5/3, 1930 (Address) 1011 N. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore cemetery

DATE OF BURIAL May 6 1930

ADDRESS 1737 E. Eager St.

20 UNDERTAKER George W. Zinkan

C. HERBERT JONES, M. D.

Spec.—1-30—M. & T.—250 Blks.

56841

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56841

33

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (No. 16-W ST. WARD)

2-FULL NAME Liston Berry

(a) RESIDENCE No. 851 Vine st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge
(State or country) Maryland

PARENTS

10 NAME OF FATHER Roland Berry

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Isabel ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address) C. Hamilton Jones, M.D.

Filed MAY 5 1930 R P K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1930, to May 2, 1930, that I last saw him alive on May 2, 1930, and that death occurred, on the date stated above, at 3.15 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

5-3, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL May 5, 1930

20 UNDERTAKER Mrs. Katie R Williams

ADDRESS 3224 Schroeder St.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56842 90 E 56842

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 Park Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C. Freburger

(a) RESIDENCE NO. 406 Park ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carroll S. Frebus

6 DATE OF BIRTH (month, day, and year): March 3-1855

7 AGE: Years 74 | Months 1 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): at Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Henry Doering

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not given

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Frene

(Address)

15 Filed: 5-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1930, to May 3, 1930, that I last saw her alive on May 3, 1930, and that death occurred, on the date stated above, at 6-30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart-disease

To my knowledge (duration) yrs. 1 mos. 25 ds.

CONTRIBUTORY (Secondary) Hemiplegia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) Frances Sue Carpenter M.D.

5-4, 1930 (Address) Med. Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: May 7 1930

20 UNDERTAKER: F. A. Krauss & Son

ADDRESS: 703 Hanover St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56843 E 56843

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 2-4 WARD)

2-FULL NAME John Parks

(a) RESIDENCE NO. 252 Wolfe St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of (Address) B. C. H.

15 Filed 5-1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4-30

17 I HEREBY CERTIFY, That I attended deceased from 12-5-25, 19..., to 5-4-30, 19...,

that I last saw h... im alive on 5-4-30, 19...,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harvey M. Stone, M. D.

5-5, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL May 6, 1930

20 UNDERTAKER Hughes & Jones Inc

ADDRESS Fort Mchenry

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56844

CERTIFICATE OF DEATH.

90 E 56844

REGISTERED NO.

1-PLACE OF DEATH ALIBON HOTEL.

CITY OF BALTIMORE: (No. 900 CATHEDRAL ST.) 11-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Cooke Dobie

(a) RESIDENCE NO. albion Hotel ST., WARD

(Usual place of abode) 900 Cathedral (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ ~~(or) WIFE~~ of Richard F. Dobie

6 DATE OF BIRTH (month, day, and year) Aug. 4th, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk, Va

PARENTS

10 NAME OF FATHER F. F. M. Cooke

11 BIRTHPLACE OF FATHER (city or town) Norfolk, Va (State or country)

12 MAIDEN NAME OF MOTHER Mary Louisa Todd

13 BIRTHPLACE OF MOTHER (city or town) Norfolk (State or country) Virginia

14 Informant T. M. Dobie

(Address) University Virginia

15 Filed 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. -, 1928, to 5-5, 1930.

that I last saw her alive on 5-1, 1930,

and that death occurred, on the date stated above, at 6.50 A m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS

HYPERTENSION

MYOCARDIAL INSUFFICIENCY

(duration) 5+ yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) 1129 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL NORFOLK. VA.

DATE OF BURIAL 5-5 1930

20 UNDERTAKER HENRY W. VENKING SON CO.

ADDRESS Orchard & McCLELLAN ST

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56845

CERTIFICATE OF DEATH.

38 E 56845

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 622 WARD)

2-FULL NAME Baby Boy Patterson

(a) RESIDENCE No. 803 N. Stricker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: B

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
			32	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Julian Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Pearl Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant (Address)

15 Filed MAY 5 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1930, to April 23, 1930, that I last saw him alive on April 23, 1930, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

Congenital Syphilis

(duration) ..... yrs. ..... mos. 32 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel T. Peters, M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: H. A. JONES, M. [illegible]

ADDRESS MAY 5 - 1930

TION is very important. See instructions on back of certificates.

Spec.—8-15-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56846

CERTIFICATE OF DEATH

100-001

E 56846

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St., 4-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Wesley

(a) RESIDENCE NO. 620 Eighth St, Laurel, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Aug. 27th, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Laurel, Md.
(State or country)

PARENTS

10 NAME OF FATHER Evan. Wesley

11 BIRTHPLACE OF FATHER (city or town) Prince Georges
(State or country) County, Md.

12 MAIDEN NAME OF MOTHER Matilda Carter

13 BIRTHPLACE OF MOTHER (city or town) Prince Geo.
(State or country) County, Md.

14 Informant Evan Wesley
(Address) Laurel, Md.

15 Filed [illegible] 19 [illegible] C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1930, to May 4, 1930, that I last saw h in alive on May 4, 1930 and that death occurred, on the date stated above, at 8:05 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? Yes No

What test confirmed diagnosis? Autopsy

(Signed) Carroll M St Clair, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Muirkirk Md.

DATE OF BURIAL May 6 1930

20 UNDERTAKER Elwood N. Fisher

ADDRESS Laurel Md

Spec.—1-12-23—M&T—500 Bks.

E 56847

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-01

E 56847

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 932 Arisquith (St.) 10-14 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Anthony

(a) RESIDENCE No. 932 Arisquith St. (St.), ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Nov 1874

7 AGE: Years 56; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James Anthony

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Henrietta Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Annie Donnelly

(Address) 932 Arisquith St.

15 Filed 5-1930. C. HAMPSON JONES, M.C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/20 1930, to 5/3 1930, that I last saw her alive on 5/2 1930, and that death occurred, on the date stated above, at 4 h. m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia Ed
Rheumatic Fever with Arthritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Rheumatic Fever Ed
colds (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) James R. Black, M.D.

5/3, 1930 (Address) 924 Arisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: May 6 1930

20 UNDERTAKER: [illegible] — ADDRESS: [illegible]

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56848

23 E 56848 (26 90)

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Turner

(a) RESIDENCE NO. 1725 - Madison ST., Case WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Turner

6 DATE OF BIRTH (month, day, and year) Unknown 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 0.D.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Car.

PARENTS

10 NAME OF FATHER Andrew Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Car.

12 MAIDEN NAME OF MOTHER Lydia Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records — (Address) JOHNS HOPKINS HOSPITAL

15 Filed 1930 19 C. RAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5-30

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to May 5, 1930, that I last saw him alive on May 5, 1930, and that death occurred, on the date stated above, at 10 05 A. m.

The CAUSE OF DEATH* was as follows:

Hypertension

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Hedwig Kaeser, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va

DATE OF BURIAL May 5 1930

20 UNDERTAKER Daniel L. Hemsley

ADDRESS W Balto

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56849 74-001 ✓ **E 56849**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1321 Scott St. 21-24 Ward)

2-FULL NAME Joseph Maddox

(a) RESIDENCE NO. 1321 Scott St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Maddox

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Priscilla Alcorn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Sophie Wood Laud
(Address) 706 Edmondson Ave

15 5-7-1930 C. HAMPSON JONES, M. D. Registrar
per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fillers, M. D.

5/5. 1930. (Address) 273 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 5-8 1930

20 UNDERTAKER Daniel Carson — ADDRESS 716 Eden

IF DEATH IS IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56850

CERTIFICATE OF DEATH.

REGISTERED NO. ×90 E 56850

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 924 E Madison St. 10-14 (WARD)

2-FULL NAME Joshua Hamid

(a) RESIDENCE NO. 924-E Madison ST., WARD Marley (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (Write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rachel Hamid

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 65; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William Hamid

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah Franklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Rachel Hamid Linwood Md.

15 Filed 5-7 1930, 19 C. HAMPSON JONES, M. D. Per RKH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 25 1930, to May 3 1930, that I last saw h— alive on May 3 1930, and that death occurred, on the date stated above, at 1:10 P m.

The CAUSE OF DEATH* was as follows: Organic Heart Disease

Contributed

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) D. Garland Thomas M. D.

May 5 1930 (Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Marley Cemetery

DATE OF BURIAL: 5-6 1930

20 UNDERTAKER: Jas. Jn. Skinner

ADDRESS: 426 E. Madison St

TION is very important See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56851

CERTIFICATE OF DEATH

E 56851

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 671 W. Fayette St. 18-16 Ward)

2-FULL NAME George T. Beasley

(a) RESIDENCE NO. Odenton, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary E. Beasley

6 DATE OF BIRTH (month, day, and year) Dec. 1866

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	63	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Librarian
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Washington, D. C.

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Beasley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Rachael Disney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. L. Waters
(Address) Odenton, Md.

15 Filed C. HAMPSON JONES, M. D.
5-1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(duration) yrs. mos. few hrs. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Kilby, M. D.

5/4. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 6 1930
20 UNDERTAKER John O. Mitchell & Son	ADDRESS 1910 Conrad Pl.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56852

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56852

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 172 S Highland ave ST., 16-7 WARD)

2-FULL NAME John Brochik.

(a) RESIDENCE NO. 172 S Highland ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Brochik

6 DATE OF BIRTH (month, day, and year) Dec 24 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant retired

(b) General nature of industry, business, or establishment in which employed (or employer) 14 years. 25

(c) Name of employer self

9 BIRTHPLACE (city or town) ..... (State or country) Bohemia

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Bohemia

14 Informant Mrs Mary Brochik

(Address) 172 S Highland ave

15 Filed ..... 19 ..... Registrar

5 1930 C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 - 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 4, 1930, that I last saw h[illegible] alive on May 4, 1930, and that death occurred, on the date stated above, at 2 [illegible] m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Liver
Heart

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia Hemiplegia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Hugh D Sudler, M. D.

5/5, 1930 (Address) 332 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL May 6 1930

ADDRESS Orleans

20 UNDERTAKER John Ulluck

Spec.—1-30—M. & T.—250 Bks.

Dr Tod
4700 Eastern Ave

E 56853 HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 56853

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3723 East Pratt ST. 16-37 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Shank

(a) RESIDENCE NO. 3723 East Pratt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) ~~WIFE~~ of Amanda Shank.

6 DATE OF BIRTH (month, day, and year) March 16-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	1	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labourer
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Arthur J Shank
(Address) 3723 E Pratt

15 Filed 5-1930, 19 per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4-1930

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to May 4th, 1930, that I last saw him alive on May 2nd, 1930, and that death occurred, on the date stated above, at 2. A. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 12 mos — ds.

CONTRIBUTORY (Secondary) Senile
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.

, 19 (Address) 4700 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Maryland

DATE OF BURIAL 5/6 1930

20 UNDERTAKER W H Cook

ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ **E 56854**

E 56854

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 336 S Mount St., 19-28 Ward)

2-FULL NAME Laura Bohlman

(a) RESIDENCE NO. 836 S Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widow

6 DATE OF BIRTH (month, day, and year): Oct. 17-1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	62	6	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: H W
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Md
(State or country)

PARENTS

10 NAME OF FATHER Jas Hubbard

11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ellen

13 BIRTHPLACE OF MOTHER (city or town): Md
(State or country)

14 Informant: John E. Bohlman
(Address) 2349 Lanvale

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia Myocarditis

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O. Brooke M. D.

May 4. 1930 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem — DATE OF BURIAL: 5/7/30

20 UNDERTAKER: Harry A. Witzke — ADDRESS: 401 Edmondson Ave

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-30—M. & T.—250 Bks.

E 56855

E 56855 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56855

CERTIFICATE OF DEATH.

#4

REGISTERED NO. 27-55

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5315 Cordelia Ave. ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert B. Smallwood

(a) RESIDENCE NO. 5315 Cordelia Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa P. Smallwood (nee Braun)

6 DATE OF BIRTH (month, day, and year) Dec. 5, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Blumenthal Kahn Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Arthur R. Smallwood, 3023 Northway Drive

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1930, to May 4, 1930, that I last saw him alive on May 2, 1930, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

— (duration) — yrs. 7 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 1929.

Was there an autopsy? no

What test confirmed diagnosis? Operative findings

(Signed) J. A. Buchness, M. D.

5/5/1930 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 5/7/30 19

20 UNDERTAKER Harry A. Witzke

ADDRESS 4 Edmondson Ave.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56856

CERTIFICATE OF DEATH.

E 56856

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 N. Broadway 6-9 WARD)

2-FULL NAME Louis Lieb Shiantsky

(a) RESIDENCE NO. 123 N. Broadway ST., WARD N.Y.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. da. How long in U. S., if of foreign birth? yrs. 7 mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tena

6 DATE OF BIRTH (month, day, and year) July 11 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
57	57	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocerier

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) Russia (State or country)

PARENTS

10 NAME OF FATHER Mendel

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Rose Karess

(Address) 193 Stone and Bvd

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 / 30

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1930, to May 5th, 1930, that I last saw h[illegible] alive on May 5th, 1930, and that death occurred, on the date stated above, at 9 30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 da.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) A. F. Ries, M. D.

May 6th, 1930 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn N. Y

DATE OF BURIAL 5/6 1930

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

E 56857 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56857

CERTIFICATE OF DEATH. † 129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital
CITY OF BALTIMORE. (No. Caton & Wilkens Ave ST. 25-12 WARD)

2-FULL NAME George Louis Burgess

(a) RESIDENCE NO. Sulphur Spring Road ST. Lansdowne WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Lydia Burgess

6 DATE OF BIRTH (month, day, and year) Oct 10. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. ... min.
	65	6	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer do
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Sharpe & Dohme

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER Owen Burgess
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore. Md
12 MAIDEN NAME OF MOTHER Elizabeth —
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. George L Burgess
(Address) Sulphur Sp. Road

Filed MAY 6 1930 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4- 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-3- 1930, to 5-4 1930.
that I last saw h alive on 5-4 1930.
and that death occurred, on the date stated above, at 4:20 P m. E.S.T.

The CAUSE OF DEATH* was as follows:
Chronic myocarditis
Chronic nephritis
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) George Brown, M. D.
5/7 1930 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk Cem
UNDERTAKER J. H. Luckman & Sons

DATE OF BURIAL May 7 1930
ADDRESS Catonsville

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56858

CERTIFICATE OF DEATH.

38 E 56858

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 713 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry H. Long (Henry Nicholas Long)

(a) RESIDENCE NO. Parkersburg W. Va WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Annie L. Long

6 DATE OF BIRTH (month, day, and year) Nov 27-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Eng

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Viscose Co

9 BIRTHPLACE (city or town) (State or country) Kent England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs A. P. Long

(Address) Parkersburg W Va

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/5/30

17 I HEREBY CERTIFY, That I attended deceased from 4/21, 1930, to 5/5, 1930

that I last saw h[illegible] alive on 5/5, 1930

and that death occurred, on the date stated above, at 5:17 P m.

The CAUSE OF DEATH* was as follows:

Meningo-Vascular Lues

Cerebral Haemorrhage

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Frederick Wolf, M. D.

5-5. 1930 (Address) Park Heights Terrace

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Md

DATE OF BURIAL May 6 1930

20 UNDERTAKER Wm J Dickey Jr

ADDRESS [illegible]

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56859 46 E 56859

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp ST. 26-41 WARD

2-FULL NAME Ella Berlach

(a) RESIDENCE NO. 4021 Parkside ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Berlach

6 DATE OF BIRTH (month, day, and year) Mar. 17-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Hepple

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Christina ?

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Hospital Record
(Address) .....

15 Filed ....., 19..... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4-30

17 I HEREBY CERTIFY, That I attended deceased from 4-19, 1930, to 5-4, 1930, that I last saw h alive on 5-3, 1930, and that death occurred, on the date stated above, at 3 45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

(duration) Unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. U. Lumpkin, M. D.

5-5, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 5/7/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56860 ✓ E 56860

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4202 Groveland Ave ST. 28-63 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James K. Merriken

(a) RESIDENCE No. 4205 Groveland Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Margaret Merriken

6 DATE OF BIRTH (month, day, and year): July 1862

7 AGE: Years 67 | Months 4 | Days 12 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Capt Fire Dept

(b) General nature of industry, business, or establishment in which employed (or employer): City of Balto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: James K Merriken

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Annabel Berlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Margaret Merriken (Address) 4205 Groveland Ave

15 Filed ..... M. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to May 3, 1930, that I last saw h~~er~~ alive on May 3, 1930, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Hypernephroma - duration about 2 mo.
Secondary anemia - duration 4 wks
Nephritis acute - duration about 4 mo

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary): Inoperable carcinoma of stomach

(duration) ....yrs. ?mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter S. Tibbitt, M. D.

May 5 1930 (Address) 2210 Harrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 5-6-30

20 UNDERTAKER: Wm Cook — ADDRESS: 1277 St Paul St.

MAY 10 1930

Spec.—1-30—M. & T.—250 Blks.

Dr Sinton 2624 St Paul St by 8:30

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56861

E 56861

CERTIFICATE OF DEATH.

REGISTERED NO. 44 E 56861

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 Poplar Grove St. 16-67 WARD)

2-FULL NAME Joshua H. Talbott

(a) RESIDENCE NO. 746 Poplar Grove ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. 25 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of or ~~WIFE~~ of Cora

6 DATE OF BIRTH (month, day, and year) 5/10/1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) Iron

(c) Name of employer Scharffer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Benjamin Talbott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss Elizabeth Talbott (Address) 746 Poplar Grove St

Filed MAY 6 1930 HAMSLEY JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/5/30 2.05 PM

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1929, to May 5, 1930, that I last saw h.. alive on May 5, 1930, and that death occurred, on the date stated above, at 2:05 P m.

The CAUSE OF DEATH* was as follows: Carcinoma of Liver

(duration) yrs. 7 mos ..... ds.

Myocarditis

CONTRIBUTORY (Secondary) (duration) yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? At his home

Did an operation precede death? Yes Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? X-Ray

(Signed) William A. Sinton M.D.

19 (Address) 2624 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 5/8 1930

20 UNDERTAKER Wilkens Ford

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

E 56862

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56862

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 27-56 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Matthews

(a) RESIDENCE NO. 3001 Oakley Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Matthews

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Matthews

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Emma ?

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Records of (Address) B. C. H.

15 Filed ....., 19..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4-30

17 I HEREBY CERTIFY, That I attended deceased from 4-23-30, 19....., to 5-4-30, 19.....,

that I last saw h. i. alive on 5-4-30, 19.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) ..... yrs. over 7 mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. over 7 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

5-5, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 5/6 1930

20 UNDERTAKER Wm Cook 1217 ADDRESS St Paul St

H. C. 1-1500

Spec.—1-30—M. & T.—250 Bks.

Dr. Bishop York Rd. Sheridan Ave 730 P.M. Gavans

E 56863 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56863

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2804 Washington ST. 35-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Richter

(a) RESIDENCE NO. 2804 Washington Blvd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of George Leo

6 DATE OF BIRTH (month, day, and year) July 26 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
39	38	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Crocker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Geo. Leo, Richter (Address) 2804 Washington Blvd.

15 Filed MAY 6 - 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 - 1930

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to May 5, 1930, that I last saw h alive on May 4, 1930, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1+ yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

May 6, 1930 (Address) 301 Shirley Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL May 8 1930

UNDERTAKER Wm Cook

ADDRESS 1217 Mt Pleasant

Spec.—1-30—M. & T.—250 Blks

E 56864

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56864

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3739 Manchester Ave. ST. 27-56 (WARD)

2-FULL NAME Eugenie Moore Morrisey

(a) RESIDENCE NO. 3739 Manchester Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Divorced.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry L. Morrisey dec'd

6 DATE OF BIRTH (month, day, and year) Dec. 1, [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hartford County.

PARENTS

10 NAME OF FATHER Samuel T. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hartford County.

12 MAIDEN NAME OF MOTHER Shepperd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County.

14 Informant Miss M. F. Moore (Sister)

(Address) Newport, Del.

15 Filed 6 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/30.

17 I HEREBY CERTIFY, That I attended deceased from Dec, 19 29 to 5/3/30, 19 ....., that I last saw h[illegible] alive on 5/2/30, 19 ....., and that death occurred, on the date stated above, at 5/4/30. 1 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma.

Fatal Coronary Occlusion

Coronary Sclerosis 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) W. H. Woody, M. D.

, 19 (Address) 1403 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Ignatius Cem. Hickory, Md.

DATE OF BURIAL 5/6/30 19

20 UNDERTAKER C. Vernon Lemmon.

ADDRESS 4611 Park Heights Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56865

CERTIFICATE OF DEATH.

129

E 56865

1-PLACE OF DEATH St Agnes Hospital 26-39

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Barbara Benda

(a) RESIDENCE NO. 4506 Ashland Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 38 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of James Benda

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER Vaclav Klima

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER Harbaug

13 BIRTHPLACE OF MOTHER (city or town) (State or country): .....

14 Informant (Address): James Benda 4506 Ashland Ave

15 Filed MAY 9 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1930

17 I HEREBY CERTIFY, That I attended deceased from 4 - 30, 1930, to 5 - 3, 1930, that I last saw h er alive on 5 - 3 -, 1930, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Blood Chemistry - Urinalysis

(Signed) Ernest Spencer Jr, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: May 7 1930

20 UNDERTAKER: Frank Enoch Son 1906 Eastlake — ADDRESS

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56866

CERTIFICATE OF DEATH

199 ✓

E 56866

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St. Jos Hosp St. 7-13 (Ward)

2-FULL NAME Jos Myner

(a) RESIDENCE NO. 920 N. Chapel St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Myner

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	73		5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 040
(c) Name of employer

9 BIRTHPLACE (city or town) Austria
(State or country)

PARENTS

10 NAME OF FATHER Jos Myner

11 BIRTHPLACE OF FATHER (city or town) Austria
(State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) Don't Know
(State or country)

14 Informant Emil Myner
(Address) 920 N. Chapel

15 Filed MAY 6 1930, 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above. by auto

The CAUSE OF DEATH was as follows: Struck while crossing street by hit and run auto

From (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract. C. R. Leg ext

Surgical Shock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ashland & Milton

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Franc M. D.

5/5, 1930 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL May 8 1930

20 UNDERTAKER Grant Crawford Son 1906 — ADDRESS Oakland

Of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56867

CERTIFICATE OF DEATH.

49

E 56867

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3713 Forrest Park Av. ST. 15-61 WARD)

2-FULL NAME Samuel Hoffman

(a) RESIDENCE NO. 3713 Forrest Park Av. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Hoffman

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) 803

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Wendel Goorman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fagie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1439 E. Balto.

Filed AY 6 - 1930 19 C. HILLEGEIST JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6-1930

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to May 6, 1930, that I last saw h alive on May 4, 1930, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of lungs

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 16, 30

Was there an autopsy?

What test confirmed diagnosis? X Ray. Pyrine examination

(Signed) Leo Brady, M. D.

19 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Howard Rm

DATE OF BURIAL 5-6- 1930

UNDERTAKER Jack Lewis, 1439

ADDRESS E Balto St

Spec.—1-30—M. & T.—250 Blks.

E 56868 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56868

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 1759 WARD)

2-FULL NAME Mrs. Sarah Michael

(a) RESIDENCE NO. 910 Mennington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Jacob Michael

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nick Lipsitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rita —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. [redacted] Baltimore St

(Address)

15 Filed [illegible] 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/5/30

17 I HEREBY CERTIFY, That I attended deceased from 4-26, 1930, to 5-5, 1930, that I last saw h[illegible] alive on 5-5, 1930, and that death occurred, on the date stated above, at 8:42 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Rt)

(Pneumococcus type II on admission)

a bone of an old T.B.

(duration) 4 yrs. 11 mos 11 ds.

CONTRIBUTORY (Secondary) Br. Pn (Left)

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. J. Cahen, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sinai Memorial Park	5-7, 1930
20 UNDERTAKER Jack Levin, 1739 E Balto	ADDRESS

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56869

CERTIFICATE OF DEATH.

3 1 E 56869

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1438 E. Lombard ST., 3-4 WARD)

2-FULL NAME Joseph Rhuderman

(a) RESIDENCE NO. 1438 E. Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Rhuderman

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fish Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Rhuderman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Louis 1439 E Baltimore St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6-1930

17 I HEREBY CERTIFY, That I attended deceased from June 28 to May 5 1930, that I last saw h.. alive on May 5, 1930, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? in Baltimore

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Exam; positive Sputum

(Signed) Jacob Cohen M. D.

5/6/30 19 (Address) 623 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arbor Rosedale DATE OF BURIAL 5-6 1930

20 UNDERTAKER Jack Lewis, 1439 ADDRESS E Balto St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56870

CERTIFICATE OF DEATH

56870

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Sinai Hospital St. 13-59 31 Ward)

2-FULL NAME Joseph Mazer

(a) RESIDENCE NO. 908 Newington Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Minnie Mazer

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	01			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant 0-5
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Jack Lewis
(Address) 1439 E. Balto., St.

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Empyema

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Weiss, M. D.

5/6/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Wash Road

DATE OF BURIAL 5-6- 1930

ADDRESS

20 UNDERTAKER Jack Lewis, 1439 E Balto St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 56871

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56871

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 Kelleley ST. 20-70 WARD)

2-FULL NAME Hazel Rosella McEuen

(a) RESIDENCE NO. 601 Kelleley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs 7 mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 11, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Montgomery Ward Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Harrison
(State or country) Balto Co.

PARENTS

10 NAME OF FATHER John F. McEuen

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Cooper

13 BIRTHPLACE OF MOTHER (city or town) Hollinsville
(State or country) Balto Co Md.

14 Informant Sophia Cooper McEuen
(Address) 601 Kelleley St.

15 Filed MAY 6 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 - 1930

17 I HEREBY CERTIFY, That I attended deceased from April 29 - 1930, to May 5 - 1930,
that I last saw her alive on May 4 - 1930,
and that death occurred, on the date stated above, at 3:00 a. m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) — yrs. 9 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Chester Rolands, M. D.

5-5- 1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Poplar Baltimore Co	May 7 1930
20 UNDERTAKER Walter R McNamara	ADDRESS Hilltop Md

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56872

44 E 56872

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1760 E. North Ave ST. 8-17 WARD)

2-FULL NAME Mary Ann Tegnor

(a) RESIDENCE NO. 1760 E. North Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Robert E Tegnor

6 DATE OF BIRTH (month, day, and year) Nov 14, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
85	86	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Elkton
(State or country) Md.

PARENTS

10 NAME OF FATHER Dickerson Elkton

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Tafpich

13 BIRTHPLACE OF MOTHER (city or town) Wilmington
(State or country)

14 Informant Mollie Rueter
(Address) 1760 E North Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10 1930, to May 5th 1930,
that I last saw her alive on May 5th 1930,
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Liver
uncertain
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure
(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Symptoms & course

(Signed) H. J. Faulkner, M. D.
, 19 (Address) 119 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 8 1930

20 UNDERTAKER Walter R. McNamee — ADDRESS 4114 Falls Rd

E. HAMPDEN GILES, M. D.

MAY 6 1930

RPK

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56873

CERTIFICATE OF DEATH

REGISTERED NO. E 56873

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 56873

1-PLACE OF DEATH

City of Baltimore: (No.) Mercy Hospital St. 11-15 Ward)

2-FULL NAME Theresia Cook

(a) RESIDENCE NO. 812 St. Paul St., Ward

(Usual place of abode) (If non-resident give city or town and State) Not known

Length of residence in city or town where death occurred 10 yrs. – mos. – ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Adolph Franz Cook

6 DATE OF BIRTH (month, day, and year): -------

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
About	73	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town):
(State or country) Germany

PARENTS

10 NAME OF FATHER Not obtainable

11 BIRTHPLACE OF FATHER (city or town): "
(State or country) "

12 MAIDEN NAME OF MOTHER "

"

13 BIRTHPLACE OF MOTHER (city or town): "
(State or country) "

14 Informant: Arthur Howard
(Address) 1301 St. Paul St.

Filed 6-1930 19.. Registrar

Via American Railway Express

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4. 30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer Pancreas

Months (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted? —
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. T. Talley, M. D.

May 4. 1930 (Address) 1639 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Dover, Delaware

DATE OF BURIAL 5/6 1930

ADDRESS

20 UNDERTAKER Henry C. Byers & Son 805 N. Calvert

IMPORTANT. See instructions on back of certificate. Use typewriter or pen and ink. Do not write in spaces not provided for. Do not use pencil. Do not abbreviate. Give statement of OCCUPATION in every case. If DEATH is due to plant items, so that it may be properly classified.

Spec.—1-30—M. & T.—250 Blks

E 56874 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56874

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. 16-42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4216 Springwood St., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carolina Buccino

(a) RESIDENCE No. 4216 Springwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alphonse Buccino

6 DATE OF BIRTH (month, day, and year) 2-18-1854

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
76	2	16 17	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Joseph Mascio

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Joseph Buccino
(Address) 4216 Springwood

15 Filed MAY 6 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5/30

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1930, to May 5, 1930, that I last saw h[illegible] alive on May 5, 1930, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? ~~Yes~~ No

What test confirmed diagnosis? Clinical

(Signed) L. Antigani, M. D.

, 19 (Address) 2942 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL 5/6/1930

20 UNDERTAKER Mary T. Ruth

ADDRESS 1735 Hoff

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56875

CERTIFICATE OF DEATH

48 ✓

E 56875

REGISTERED NO. 43

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3015 Glenmore Ave ST., Keelsdale WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Sitting

(a) RESIDENCE NO. 3015 Glenmore Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 11 mos. 8 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 25 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ft Wayne Ind.

PARENTS

10 NAME OF FATHER August C Sitting

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margt. Goetze

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Dederer

(Address) 3015 Glenmore Ave

15 Filed 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov 2 1930, to May 3 1930, that I last saw h alive on May 3 1930, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion — Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Face

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas F Turner, M. D.

(Address) May 4. 1930 4 N Howard Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls Cem. Violetville — DATE OF BURIAL 5-6 1930

20 UNDERTAKER Mrs Chas A Golde — ADDRESS 2327 Edmondson Ave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56876

CERTIFICATE OF DEATH.

101-801

E 56876

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1626 Vincent St., 15-21 (WARD)

2-FULL NAME Minnie Brown

(a) RESIDENCE NO. 1626 Vincent ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Brown

6 DATE OF BIRTH (month, day, and year) Feb 15 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Clay Wallace

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Green

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mabel Allen
(Address) 1635 Vincent St

15 Filed MAY 6 - 1930 Register

HAMPTON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 30, 1930, to May 4, 1930, that I last saw her alive on May 4, 1930, and that death occurred, on the date stated above, at 12-15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C Williams Frey, M. D.

5/6, 1930 (Address) 1928 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 5/6 1930

20 UNDERTAKER Frank T Bromley

ADDRESS 578 N Eutaw

Spec.—1-30—M. & T.—250 Bks.

E 56877 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56877

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 90

CITY OF BALTIMORE: (No. 17-24 St., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Sutton

(a) RESIDENCE NO. 536 Camel St., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-2-30

17 I HEREBY CERTIFY, That I attended deceased from 2-25-29, 19..., to 5-2-30, 19...,

that I last saw her alive on 5-2-30, 19...,

and that death occurred, on the date stated above, at 12 N. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; Hypertension

(duration) yrs. 15 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

5-3, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interment

DATE OF BURIAL 5 6 1930

20 UNDERTAKER Frank P. Brindley & Bro.

ADDRESS 578

Spec.—1-10-21—M&T—1500 Bks.

E 56878 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56878

CERTIFICATE OF DEATH. 135

REGISTERED NO.

1-PLACE OF DEATH Md General Hosp. 11-24

CITY OF BALTIMORE: (NO. 1 Howard & Madison ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Council

(a) RESIDENCE NO. Hollathorpe, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Council

6 DATE OF BIRTH (month, day, and year) Mar 24, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer) Produce

(c) Name of employer self.

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Council

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record (Address)

15 Filed MAY 6 1930 [illegible] HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1930

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1930, to May 6, 1930, that I last saw h alive on May 6, 1930, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Prostate

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Kupelwieser, M. D.

5/6, 1930 (Address) Md General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL May 8 1930

20 UNDERTAKER Harry N. Arnaud — ADDRESS 4202 Ridgewood Ave.

See instructions on back of certificates. TION is very important.

Spec.—2-29-28—L. F. S.—590 Bks.

Fields

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56879 ✓ 129 E 56879

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 n Dallas ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Fields

(a) RESIDENCE NO. 418 n Dallas St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (city or town) (State or country) unk

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unk

14 Informant Rose Williams

(Address) 418 n Dallas St

MAY 6 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4-30

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1930, to May 4, 1930, that I last saw h alive on May 4, 1930 and that death occurred, on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

(duration) yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Jno S Adler, M. D.

5-5, 1930 (Address) 58 Somerset St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Antrim Cem.

DATE OF BURIAL 5/7/30

20 UNDERTAKER [redacted] ADDRESS 1231 Eutaw St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56880

CERTIFICATE OF DEATH.

46

E 56880

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Marie Luker

(a) RESIDENCE NO. 225 S. Caroline St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Shields

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Emma ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 9 AM C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-1-30

17 I HEREBY CERTIFY, That I attended deceased from 11-26-29, 19..., to 5-1-30, 19...,

that I last saw her alive on 5-1-30, 19...,

and that death occurred, on the date stated above, at 5:45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix Uteri

(duration) over 5 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marion M. McLean, M. D.

5-1, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health

MAY 6 - 1930

Spec.—1-30—M. & T.—250 Blks.

E 56881 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 56881

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Cornelius Overton

(a) RESIDENCE NO. 911 Shuter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Samuel Overton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of (Address) B. C. H.

15 Filed MAY 6-1930 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-1-30

17 I HEREBY CERTIFY, That I attended deceased from 3-19-30, 19..., to 5-1-30, 19..., that I last saw him alive on 5-1-30, 19..., and that death occurred, on the date stated above, at 11-55 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic & acute

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. McCready, M. D.

5-2, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

20 UNDERTAKER Commissioner Health.

By Wm E. WOOSAL

DATE OF BURIAL 19

ADDRESS MAY 5 - 1930

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56882 ✓ 185 E 56882

CERTIFICATE OF DEATH

E 56882

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 W. Fayette ST.) 18-16 (WARD)

2-FULL NAME Alfred McRoy

(a) RESIDENCE NO 916 W. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Alfred McRoy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Green

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant .....
(Address) .....

15 Filed ..... C. HAMPSON GIBBES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion of Brain
Accidental Death. Fell
from Father's arms ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Convulsions
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Eugene Feldes, M. D.
Coroner

5/5, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
UNIVERSITY OF MARYLAND

DATE OF BURIAL
MAY 6 - 1930

20 UNDERTAKER
Commissioner Health.

ADDRESS .....

Per Wm E WOODALL

TION is very important. See instructions on back of certificates.

81 - 9 AM

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56883

E 56883

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 526 N Stinghams St. Ward 71

2-FULL NAME Mary A Bailey

(a) RESIDENCE NO. 526 N Stinghams St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-1855

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75	—	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Ireland

(State or country)

10 NAME OF FATHER Michael Bailey

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Bridget Carroll

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Mrs. C. Hampton Jones

(Address) 526 N Stinghams St

15 Filed MAY 6 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1930

17 I HEREBY CERTIFY, That I attended deceased from April-10, 1930, to May 4, 1930, that I last saw her alive on May 4, 1930, and that death occurred, on the date stated above, at 8:50 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia - Cardiac Failure (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & Surgical

(Signed) , M. D.

, 19 (Address) Med. Art Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 5/7 1930

20 UNDERTAKER ADDRESS

Of DEATH in plain terms, so that it may be properly classified. Part Statement of OCCUPATION is very important. See instructions on back of certificates.

6-1930

Spec.—1-10-21—M&T—1500 Bks.

E 56884

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56884

Maier 57

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital ST. 8-17 (WARD)

2-FULL NAME George Meyer Maier

(a) RESIDENCE NO. 1025 N. Durham ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kunagunda Maier

6 DATE OF BIRTH (month, day and year) 6/21/1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ... min.
74	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frankfort Germ.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mrs. Maier (Address) 512 Ensor St.

15 Filed ... 19 ... Registrar

6-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-5 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-2-30 .19 ... to 5-5-30 .19 ...,

that I last saw him alive on 5-5-30 .19 ...,

and that death occurred, on the date stated above, at 1.45 A. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. 2 mos 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ... 20

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) W B Hendrix, M. D.

.19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 5/8/30 19

20 UNDERTAKER Jno. J. Duffy & Sons

ADDRESS 1135 Waf-1

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56885 ✓

E 56885

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1008 Somerset St. 10-14 Ward)

2-FULL NAME Elizabeth Brenneis

(a) RESIDENCE NO. 1008 Somerset St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1848

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	82	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baden-Baden
(State or country) Germany

PARENTS

10 NAME OF FATHER Karl Beenneis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baden-Baden, Germany

12 MAIDEN NAME OF MOTHER Anna Maria xxxxxx

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baden-Baden, Germany

14 Informant Barbara Praller
(Address) 1035 Auburn St

Filed 5-8 1930 19 C. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature] M. D.
5/7/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL May 8 19 30

20 UNDERTAKER Henry Hoeck & Sons, Inc. — ADDRESS 1301 E Eager

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56886

E36865-40

E36886

+49

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2—FULL NAME Lillian Getson

(a) RESIDENCE NO. Lonaconing ST. Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None - Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER Charles Getson

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Messy

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 6 - 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 30

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1930, to May 6, 1930, that I last saw her alive on May 6, 1930 and that death occurred, on the date stated above, at 10 15 a. m.

The CAUSE OF DEATH was as follows:

Hypertrophical Cirrhosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-9-30

Was there an autopsy? Yes

What test confirmed diagnosis? X ray

(Signed) Child Surgeon, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lonaconing, Md.

DATE OF BURIAL May 9 1930

20 UNDERTAKER Wm. J. Tuckerton

ADDRESS North Potomac

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56887

CERTIFICATE OF DEATH

E 56887

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 372 N. Gilmor St. 14-27 Ward)

2-FULL NAME Henry W. Thomas

(a) RESIDENCE NO. 372 N. Gilmor St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Thomas

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	87			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) W. Va.
(State or country)

PARENTS

10 NAME OF FATHER David Thomas

11 BIRTHPLACE OF FATHER (city or town) W. Va.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Burke

13 BIRTHPLACE OF MOTHER (city or town) W. Va.
(State or country)

14 Informant Nellie Green
(Address) 372 N. Gilmor St.

15 Filed MAY 6 1930 C. HERMON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.
thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis 1 yr.
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? W. Va.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. Bullock, M. D.
(Address) May 7 1930 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harpers Ferry, W. Va.

DATE OF BURIAL May 7, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 W. Schroeder St.

Y C - 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 56888 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56888

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 18-26 31

CITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Ames

(a) RESIDENCE NO. 1108 Sarah Ann st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thelma Ames

6 DATE OF BIRTH (month, day, and year) Oct. 13, 1905

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	24	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe factory

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Virginia

PARENTS

10 NAME OF FATHER Willie Ames

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sophie Ferguson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Virginia

14 Informant Hospital Records
(Address)

Filed 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1930, to May 3, 1930, that I last saw him alive on May 3, 1930, and that death occurred, on the date stated above, at 8.25 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) [signature], M. D.

5-4-1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL May 6 1930

20 UNDERTAKER Mrs Katie R. Williams — ADDRESS 20 Lethrop St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56889

CERTIFICATE OF DEATH

89 E 56889

REGISTERED NO. 16-68

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lawrence E. Smith

(a) RESIDENCE NO. 611 Ashburton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha L. Smith

6 DATE OF BIRTH (month, day, and year) Jan. 8" 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chute Builder

(b) General nature of industry, business, or establishment in which employed (or employer) Metal

(c) Name of employer Metal Package Corp.

9 BIRTHPLACE (city or town) Rome
(State or country) New York

PARENTS

10 NAME OF FATHER Horace Smith

11 BIRTHPLACE OF FATHER (city or town) Rome
(State or country) New York

12 MAIDEN NAME OF MOTHER Mary Lonin

13 BIRTHPLACE OF MOTHER (city or town) Rome
(State or country) New York

14 Informant Mrs. M. L. Smith
(Address) 611 Ashburton St.

15 Filed 6-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 4" 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1929, to May 4, 1930, that I last saw him alive on May 4, 9 A. M. 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

angina pectoris.

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual sts.

(Signed) George A Kunz, M. D.

, 19 (Address) 3038 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL May 7" 1930

20 UNDERTAKER Fred'k B Cook

ADDRESS 1002 Park Ave

Spec.—2-29-28—L. F. S.—500 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56890 129 E 56890

E 56890

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 N. Gilmor ST. 16-27 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Matilda K. Schaefer

(a) RESIDENCE NO. 630 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 11, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Jean Schaefer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Bavaria

12 MAIDEN NAME OF MOTHER Margaret Kett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Bavaria

14 Informant Miss Sophie Schaefer

(Address) 1324 L St., N.W. Washington, D.C.

15 Filed ..... 19 ..... Registrar

1930 C. HAMPSON LEWIS, M.D. Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 3, 1930, to May 5, 1930, that I last saw her alive on May 5, 1930 and that death occurred, at the date stated above, at 2.45 P. m. (D. S. T.)

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis + mitral regurgitation.

(duration) 3 ay yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) M Bowman Hood, M. D.

5/5, 1930 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

20 UNDERTAKER Joseph D. Cook

DATE OF BURIAL May 7, 1930

ADDRESS 1003 West Baltimore St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56891

CERTIFICATE OF DEATH.

E 56891

REGISTERED NO. 57

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Lover ST. 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Kronau Mollie E.

(a) RESIDENCE NO. 3212 Batavia Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry M. Kronau

6 DATE OF BIRTH (month, day, and year) May 20, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William B. Eslin

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mollie

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mr. Harry M. Kronau, Jr. (Address) Hopkins Apartments

15 C. HAMPSON JONES, M. D. Registrar

6 - 1930 19 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 5 1930

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1930, to May 5, 1930, that I last saw h[illegible] alive on May 5, 1930, and that death occurred, on the date stated above, at 2.55 P m. (S. T.)

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Vincent Messina M. D.

5/5, 1930 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL May 8 1930

20 UNDERTAKER Joseph L. Cook

ADDRESS 1003 West Baltimore St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56892 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56892

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 Homewood Ave. WARD) 9-18

2-FULL NAME Jean H. Coppinger

(a) RESIDENCE NO. 1317 Homewood Ave. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 25, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER John J. Coppinger

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Agnes H Boylan

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Aunt Miss Jane H. Brogan
(Address) 1317 Homewood Ave

15 Filed 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to May 5, 1930, that I last saw her alive on May 5, 1930, and that death occurred, on the date stated above, at 10 a m.

THE CAUSE OF DEATH* was as follows:

Lobar Pneumonia, Left lower Lobe (unresolved)

(duration) ..... yrs. mos 16 ds

CONTRIBUTORY (Secondary) Congenital Valvular Heart Lesion (Incompetency)
(duration) 9 yrs. ..... mos. Life ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Wm. R. Straight M. D.

5/6/30 (Address) 2225 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL May 8, 1930

20 UNDERTAKER Elmer W Conklin ADDRESS 924 E. Eager St

Spec.—1-30—M. & T.—250 Blks.

E 56893 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56893

31

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (ST. 18-26 WARD)

CITY OF BALTIMORE: (NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addie Edwards

(a) RESIDENCE NO. 517 N. Schroederst. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5. Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Edwards

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
38	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Cubit Rivers

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Catherine McCoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital records.

(Address)

15 Filed 6-1930, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1929, to May 2, 1930,

that I last saw her alive on May 2, 1930,

and that death occurred, on the date stated above, at 1.10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M.D.

5-2, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 5/7, 1930

20 UNDERTAKER Bernard Newsby

ADDRESS 718 N. Dallas St.

Spec.—1-30—M. & T.—250 Blks.

E 56894 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56894

CERTIFICATE OF DEATH. 101-08

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 N Paca ST. 17-25 WARD

2-FULL NAME Alexander Gross

(a) RESIDENCE NO. 637 N Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1874

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	55	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Chas Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maria Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lucy Gross (Address) 637 N Paca St

15 Filed MAY 6 1930 C. HAMPSON JONES, M. D. Registrar

Per RR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1930

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1930, to May 5, 1930, that I last saw him alive on May 5, 1930, and that death occurred, on the date stated above, at 11-20 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Harry E. Wagner M. D.

5/6, 1930 (Address) 1005 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Chapel Calvert Co.

DATE OF BURIAL 5-7 1930

UNDERTAKER Samuel T. Hensley

ADDRESS Mitchellville

Spec.--1-30--M. & T.--250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56895

E 56895

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 27-3 WARD

2-FULL NAME Charles H. Clausen

(a) RESIDENCE NO. 4612 Roland ave Balto WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 9 mos. 24 ds. How long in U. S., if of foreign birth? 72 yrs. 9 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma B Clausen

6 DATE OF BIRTH (month, day, and year) July-10-1857

7 AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
	72	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bkkpr Md Lumber Cement Co

(b) General nature of industry, business, or establishment in which employed (or employer) Ofc

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry W Clausen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Luetta Sheir

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) J. F. Shafer (son-in-law) Fords Lane Balto

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

6 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/30.

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to May 4, 1930, that I last saw him alive on May 4, 1930, and that death occurred, on the date stated above, at 5 50 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Electrocardiogram

(Signed) W. T. Bird, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cemetery

DATE OF BURIAL May 19 30

20 UNDERTAKER Stewart Mowell

ADDRESS Balto

Spec.—1-30—M. & T.—250 Blks

James R. Martin ✓

E 56896 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56896

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2908 Kenwick Road (S.) 13-52 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James R Martin

(a) RESIDENCE NO. 2908 Kenwick Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie B Martin

6 DATE OF BIRTH (month, day, and year) Dec 22 1857

7 AGE Years.	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired RR conductor

(b) General nature of industry, business, or establishment in which employed (or employer) RR

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Annie B Martin (Address) 2908 Kenwick Road

15 Filed MAY 6 - 1930 C. HAMPSON JONES, By HKH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to May 5, 1930, that I last saw her alive on May 4, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Myocarditis & chronic Interstitial Nephritis

(duration) 5 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos Shewell, M. D.

5/6, 1930 (Address) 846 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Grove Balto Co

DATE OF BURIAL May 7 1930

UNDERTAKER Ellinsworth & Son

ADDRESS 2610 Eutaw

Spec.—1-30—M. & T.—250 Blks

E 56897 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56897

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 4311 Falls Road ST., 27-49 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thurman K Ensor

(a) RESIDENCE NO. 4311 Falls Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 20 1912

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
18	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 59 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel T. Ensor

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Bessie V Zell

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Samuel T. Ensor
(Address) 4311 Falls Road

15 Filed ..... 19 1930 Registrar C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1930, to May 5, 1930, that I last saw him alive on May 5, 1930, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis (Pulmonary)

(duration) yrs. mos 33 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? →

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray.

(Signed) M. Gibson Porter, M. D.

May 9, 30 (Address) 4822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Grove Balto Co.

DATE OF BURIAL May 8 1930

20 UNDERTAKER Chenoweth Son

ADDRESS 3615 Chestnut

Spec.—1-12-23—M&T—500 Bks.

E 56898

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56898

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (NO.) Mt. St. agnes College ST. Wash'g'n Rd WARD

2-FULL NAME Sister mary Christida monaghan

(a) RESIDENCE NO. Mt St agnes College ST. Washington WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 5, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	83	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Monaghan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Barry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mother M. Josepha Mt. Washington

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1927. to May 2. 1930.

that I last saw h[illegible] alive on May 2, 1930,

and that death occurred, on the date stated above, at 2 25 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardio Vascular Disease

Cardiac Decompensation

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) N. R. Peters, M. D.

, 19 (Address) 1908 W. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] Cemetery

DATE OF BURIAL: May 8 1930

20 UNDERTAKER: [illegible]

ADDRESS: Eutaw & Fayette Sts

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56899

E 56899

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3203 Evergreen Av) St. 27-43 WARD 24

2-FULL NAME Emma J. Colton

(a) RESIDENCE NO. 3206 Evergreen Av St., Hamilton WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): widow

6a If married, widowed, or divorced (b) WIFE of: Theodore Colton

6 DATE OF BIRTH (month, day, and year): Sept 23 1848

7 AGE: Years 81. Months 7. Days 12 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Nathaniel Bright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): John C Brotherhood 3203 Evergreen

Filed May 6 1930 Registrar WPB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 5 1930

17 I HEREBY CERTIFY, That I attended deceased from May 2 1930 to May 5 1930

that I last saw h alive on May 6 1930

and that death occurred, on the date stated above, at 1 25 m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) John C Cruz M. D.

May 6 1930 (Address) 5621 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: May 8 1930

20 UNDERTAKER: William Cook

ADDRESS 1217 St Paul

Spec.—1-12-23—M&T—500 Blks.

E 56900

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56900

CERTIFICATE OF DEATH.

100-081

21-29

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1309 Glyndon Ave., ST. (WARD)

2-FULL NAME Jack N. Matthews

(a) RESIDENCE NO. 1309 Glyndon Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20/28

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Napoleon Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nellie Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Napoleon Matthews
(Address) 1309 Glyndon Ave.

15 Filed ..... 19 ..... Registrar

6 - 1930

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1930

17

I HEREBY CERTIFY, That I attended deceased from April 28th, 1930 to May 5th. 1930

that I last saw him alive on May 5th. 1930

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Anaemia

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pneumonia (bronchial)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Carahan, M. D.

5/6, 1930 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 5/7 1930

20 UNDERTAKER Wm. Cook

ADDRESS 1217 St. Paul Street.

Spec.—1-30—M. & T.—250 Bks.

Dr. Frank J. Ayd 2005 E Monument near Washington

E 56901 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56901

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N. Rose st St. 7-10 WARD)

2-FULL NAME Emma Adams

(a) RESIDENCE NO. 520 N. Rose ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of or) WIFE of Robt. A. Adams

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Geo Marshall

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Lavinia Preston

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Robt. A. Adams (Address) 520 N. Rose St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/6/30

17 I HEREBY CERTIFY, That I attended deceased from June, 1930, to May 5, 1930, that I last saw h alive on May 5, 1930, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Metastatic carcinoma of Labia etc.

(duration) yrs. 4 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Laboratory

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

May 6, 1930 (Address) 2005 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL 5/8/1930

20 UNDERTAKER Wm Cook — ADDRESS 1219 St Paul St

Spec.—1-30—M. & T.—250 Bks.

Dr. Fisher 1823 N Washington St / Wolf 5134 / 7 to 8

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56902

CERTIFICATE OF DEATH.

129

E 56902

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 N. Collington Ave. St.) 8-16 (WARD)

2-FULL NAME Nellie Bremer

(a) RESIDENCE NO. 1511 N. Collington Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Peter Bremer

6 DATE OF BIRTH (month, day, and year) 7/19/1844

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
85	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Holland

PARENTS

10 NAME OF FATHER Ferdinand Von Kleef

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant (Address) Mrs Fred Gerhardt 1511 Collington Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/6/30

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1930, to May 6, 1930, that I last saw her alive on May 6, 1930, and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

5/6 1930 (Address) 1823 N. Washington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 5/8/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56903

E 56903

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 N. Carey ST. 15-21 WARD)

2-FULL NAME Ethel M. Rusk

(a) RESIDENCE NO. 1710 N. Carey ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 1-1908

7 AGE: Years 21 | Months 8 | Days 4 | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. J. Rusk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Jennie Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Barbara Butler

(Address) 1710 Carey

Filed MAY 6 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1930, to May 5, 1930,

that I last saw h[illegible] alive on May 4, 1930

and that death occurred, on the date stated above, at 12.30 A. m

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morley Craig, M. D.

May 6, 1930 (Address) 729 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 5/7/1930

UNDERTAKER Geo. Geo. H. Holland

ADDRESS 601 Druid Hill Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 56904

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 56904

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. President Hospital 15-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Myers

(a) RESIDENCE NO. 1364 N. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of George Myers

6 DATE OF BIRTH (month, day, and year) May 16, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	62	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) Mitchenin (State or country) Va

PARENTS

10 NAME OF FATHER Jessie Watts

11 BIRTHPLACE OF FATHER (city or town) Mitchenin (State or country) Va

12 MAIDEN NAME OF MOTHER Martha (P)

13 BIRTHPLACE OF MOTHER (city or town) Mitchenin (State or country) Va

14 Informant Lillian Rickman (daughter) (Address) 1364 N Calhoun St

15 Filed 6-1930 C. HAMPSON JONES, M. Registrar By ACS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3-30

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to May 3, 1930, that I last saw h... alive on May 3, 1930 and that death occurred, on the date stated above, at 2 20 P m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio-Vascular Disease: Arteriosclerosis (duration) about 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Hemorrhagic Pancreatitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) Carroll M St Clair, M. D.

, 19 (Address) President Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 5/7/ 1930

UNDERTAKER Mrs Geo. H. Holland

ADDRESS 1631 Druid Hill Ave

Spec.—8-16-29—L. F. S.—100 Bks.

118-001 ✓

E 56905 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56905

CERTIFICATE OF DEATH

REGISTERED NO. 27-54

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grace Virginia Kittle

(a) RESIDENCE NO. 2206 Kenwalk Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward C. Kittle

6 DATE OF BIRTH (month, day, and year) ~~~~ 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER ~~~ Childress

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Not obtainable

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Mrs Polly M. Kittle

(Address) 2206 Ken Oak Road

15 Filed ....., 19..... By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6-30

17 I HEREBY CERTIFY, That I attended deceased from 5-5, 1930, to 5-6, 1930

that I last saw h alive on 5-6, 1930

and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Hernia - Femoral - Left

(duration) ....yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) ....yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 5-5-30

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. C. Porterfield, M. D.

5-6, 1930 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 5/8 1930

UNDERTAKER Henry U. Mentz and Son ADDRESS 805 N. Calvert St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56906

CERTIFICATE OF DEATH

129 E 56906

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 N. Collington ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Rausch

(a) RESIDENCE NO. 401 N. Collington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Rausch

6 DATE OF BIRTH (month, day, and year) June 3, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 011

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bavaria

PARENTS

10 NAME OF FATHER John Rausch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Celia M. Schaufler

(Address) 401 N. Collington

15 Filed 6 1930 G. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 - 30

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to May 5, 1930, that I last saw him alive on May 5, 1930, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis; Arteriosclerosis; Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) James F. Weiss, M. D.

5/6, 1930 (Address) Essex, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL 5/7/ 1930

20 UNDERTAKER John G. Connelly

ADDRESS Essex

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56907 — 90 E 56907

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Provident Hospital ST. 1623 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Hurst

(a) RESIDENCE NO. 1008 Lafayette Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Haitian Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of K Bertha Hurst

6 DATE OF BIRTH (month, day, and year) May 10, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66 67	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bishop

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Port au Prince (State or country) Haiti

PARENTS

10 NAME OF FATHER Henry Hurst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sylvanie ?

13 BIRTHPLACE OF MOTHER (city or town) Haiti (State or country)

14 Informant B Bruce Hurst (son)

(Address) 1327 Q St N.W. Washington D.C.

15 Filed 7-1930 C. HAMILTON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6-30

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to May 6, 1930, that I last saw h in alive on May 6, 1930 and that death occurred, on the date stated above, at 3.05 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerotic Cardio Vascular Disease (duration) about 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M. St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem.

DATE OF BURIAL 5/9 1930

20 UNDERTAKER J Reuben Whitehurst & Wm Hoffa Sr.

ADDRESS

Spec.—8-16-29—L. F. S.—100 Bks.

E 56908

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56908

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 11-7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Anderson

(a) RESIDENCE NO. 20 E. Hamilton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Anderson

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter and

(b) General nature of industry, business, or establishment in which employed (or employer) Jobber

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary E. Hawkins

(Address) 20. E. Hamilton

15 Filed MAY 7 - 1930 C. HAMPSON JONES, M. D. Registrar GKG

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-5-30

17 I HEREBY CERTIFY, That I attended deceased from 3-7-30, 19, to 5-5-30, 19, that I last saw h. was alive on 5-5-30, 19, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral Pulmonary T.B.

Prostatic hypertrophy & Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) uraemia & pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 4/28/30

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Leroy S. Peck, M. D.

5-6 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery

DATE OF BURIAL May 8th 1930

20 UNDERTAKER Wm. H. Crase & Son

ADDRESS 1400 Mosher

Spec.—1-10-21—M&T—1500 Bks.

E 56909 HEALTH DEPARTMENT—CITY OF BALTIMORE 111-001

CERTIFICATE OF DEATH. E 56909

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 425-75 WARD)

2-FULL NAME James F. Wilkinson

(a) RESIDENCE NO. 409 Patapsco Ave ST., Brooklyn WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Blanche M Wilkinson

6 DATE OF BIRTH (month, day, and year) Mar 21 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	52	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Crane Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Friendship Anne Arundel Co

PARENTS

10 NAME OF FATHER William Wilkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Child

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co. Md

14 Informant Robert O Wilkinson

(Address) 3709 Monroe St

15 Filed MAY 7 1930 HARRY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/5/30 19

17 I HEREBY CERTIFY, That I attended deceased from 4/6/30 .19.... to 5/5/30 .19.... that I last saw h— alive on 5/5/30 .19.... and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

gastric ulcer

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) cardiac decompensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/22/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W D Kendrick M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery DATE OF BURIAL May 8 1930

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56910

E 56910

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2904 Ellicott Drive WARD) 16-67

2-FULL NAME Forest O. Bayless

(a) RESIDENCE NO. 2904 Ellicott Drive ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or WIFE of) Marguerite C. James

6 DATE OF BIRTH (month, day, and year) May 8th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City Ashing

9 BIRTHPLACE (city or town) (State or country) Washington, D. C.

PARENTS

10 NAME OF FATHER Bayless

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Marguerite C. James

(Address) 2909 Ellicott Drive

15 Filed MAY 7 - 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/5/30

17 I HEREBY CERTIFY, That I attended deceased from March 29th, 1930, to May 5th, 1930, that I last saw him alive on May 5th, 1930, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Syncope

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hamilton Jones, M. D.

May 7, 1930 (Address) 711 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 5/7/1930

20 UNDERTAKER F. A. Wyglint — ADDRESS 1850 N. Baltimore St

Spec.—1-30—M. & T.—250 Blks

Dr Ries

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 56911

E 56911

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4415 Harcourt Rd. ST. 27th WARD

2-FULL NAME Bartholomew Nolan

(a) RESIDENCE NO. 4415 Harcourt Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Nolan

6 DATE OF BIRTH (month, day, and year): 1850

7 AGE: about 80 yrs!

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Penn. R.R. 03

(b) General nature of industry, business, or establishment in which employed (or employer): R.R. Engineer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: James Nolan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Kath. Redman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: M. J. McGrath (Address) 4405 Harcourt Rd

15 Filed ..... 19 ..... Registrar

V T - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4/30

17 I HEREBY CERTIFY, That I attended deceased from Apr. 15th, 1930, to May 4th, 1930, that I last saw him alive on May 3rd, 1930, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia 1 day

Cardiac Hypertrophy, Arteriosclerosis, Chronic Interstitial Nephritis

(duration) some yrs. mos. ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory Exam.

(Signed) G. F. Ries, M. D.

May 7th, 1930 (Address) 24 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: May 8 1930

20 UNDERTAKER: John A. Moran — ADDRESS: 3500 E. Baltimore St.

R.H.K.

Spec.—1-30—M. & T.—250 Bks.

E 56912

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56912

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. 27-56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 4804 Park Heights (St.) (Ward)

2-FULL NAME Charles Cassell Earp

(a) RESIDENCE NO. 4804 Park Heights (St.), WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	widowed

5a If married, widowed or divorced HUSBAND of ~~(or) WIFE of~~ Martha A. Earp

6 DATE OF BIRTH (month, day, and year) June 28, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) watchman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Johnathan Earp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Matilda Ellen Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Charles A. Earp

(Address) 4804 Park Heights Ave

MAY 7 - 1930 C. HAMILTON JOHNS, Registrar

MEDICAL CERTIFICATE ~~OF~~ DEATH

16 DATE OF DEATH (month, day, and year) May 5. 1930

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1930, to May 5, 1930, that I last saw him alive on May 5th, 1930, and that death occurred, on the date stated above, at 6.53 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal observation

(Signed) Wm Conrad Bode, M. D.

5/6, 1930 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL May 8 1930

20 UNDERTAKER Wm J. Thebaud Sons

ADDRESS Baltimore

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56913

CERTIFICATE OF DEATH

3/√ E 56913

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., 24-33 Ward)

2-FULL NAME William Moran.

(a) RESIDENCE NO. Do not know. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	40	----	------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER Michael Moran.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Harry Hassett.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Hospital Report.
(Address) So. Balto. General Hospital.

Filed MAY 7 1930 19 C. HERBERT EVANS M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APRIL 8, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Otto M. Einhardt, M. D.

5/5, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
PUBLIC CEMETERY.

20 UNDERTAKER

DATE OF BURIAL 19

ADDRESS MAY 7 - 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56914 E 56914

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

REGISTERED NO. 12-51

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 W. Twenty Ninth ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W. P. Insley

(a) RESIDENCE NO. 217 W. Twenty Ninth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Nina Webb Insley

6 DATE OF BIRTH (month, day, and year) June 28, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bivalve Wicomico Co., Md.

PARENTS

10 NAME OF FATHER George D. Insley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan P. Horseman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Nina Webb Insley

(Address) 217 W. Twenty Ninth St.

15 Filed MAY 7 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to May 6, 1930

that I last saw him alive on May 6, 1930

and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Arteriolar Fibrillation

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. H. Woolley, M. D.

19 (Address) 140 E. Redwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bivalve, Wicomico Co., Md.

DATE OF BURIAL May 7, 1930

UNDERTAKER E. Leroy Stiffler, Inc.

ADDRESS 125 E. North Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 56915

REGISTERED NO. 16-67

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 N Fulton ST., WARD)

2—FULL NAME Mary A Frestell

(a) RESIDENCE NO. 1515 N Fulton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 12 1854

7 AGE: Years 75 | Months 9 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Gds

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Michael Mulvey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Alice Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs B J Frestell
(Address) 1515 N Fulton

15 Filed 7-1930 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 5, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 30 —, 1930, to May 5, 1930

that I last saw her alive on May 5, 1930

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia 1 day.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis - Chronic (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

5/6, 1930 (Signed) Amerigo Lozello, M. D. (Address) 3705 Liberty Hgts. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 5/8 1930

20 UNDERTAKER: Geo A Farley

ADDRESS: Fulton & Fayette

Spec.—1-30—M. & T.—250 Blks.

E 56916 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56916

CERTIFICATE OF DEATH.

REGISTERED NO. 89 76-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 637 S. Conkling ST., [illegible] WARD)

2-FULL NAME John L. Mc Millan

(a) RESIDENCE NO. 637 S. Conkling ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha McMillan

6 DATE OF BIRTH (month, day, and year) July 5. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Gas Plant

(c) Name of employer

9 BIRTHPLACE (city or town) Scotland (State or country)

PARENTS

10 NAME OF FATHER James Mc Millian

11 BIRTHPLACE OF FATHER (city or town) Scotland (State or country)

12 MAIDEN NAME OF MOTHER Euphamia McMillan

13 BIRTHPLACE OF MOTHER (city or town) Scotland (State or country)

14 Informant Duncan Mc Millan (Address) 306 Marshall St.

15 Filed 7 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 1930, to May 7th, 1930, that I last saw him alive on May 6th 1930, and that death occurred, on the date stated above, at 3. a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 6 mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Otto J. Schindler M. D.

19 (Address) 451 Eastern Ave. City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elizabeth Evergreen Cemetery

DATE OF BURIAL May. 8 1930

ADDRESS 4032. Wash Ave

20 UNDERTAKER Lilly & Geiler Inc

C. HARRISON JOHNS, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56917

CERTIFICATE OF DEATH

166 ✓ E 56917

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St. 19-28 Ward)

2-FULL NAME Gertrude Francis Lydon

(a) RESIDENCE NO. 238 S. Fulton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas Lydon

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Jno. Burke

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER McGuigan

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Thomas Lydon
(Address) 4435 Parkside

15 Filed May 6, 1930 C. HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Caused by Acute Cerebral Hemorrhage

14 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Autopsy

(Signed) W. [illegible], M. D.

May 6, 1930 (Address) 1059 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	5/8/30 19
20 UNDERTAKER C. Vernon Lemmon	ADDRESS 4611 Park Heights Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56918

CERTIFICATE OF DEATH

167-001

E 56918

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1625 Ensor St., 9-18 Ward)

2-FULL NAME Cecelia V. Cherry

(a) RESIDENCE NO. 1625 Ensor St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm. J. Cherry

6 DATE OF BIRTH (month, day, and year) Aug 6/1888

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	42	9	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Joseph C. O'Neill

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary C. James

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Wm. J. Cherry
(Address) 1625 Ensor St

15 FILED 5-1930 16 C. HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Illuminating Gas Asphixiation
Suicide- (Gas tube from pipe for heating stove)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Haines, M. D.

5/6/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 5 1930
20 UNDERTAKER Mary M Mudge	ADDRESS 501 E 22nd St

Spec.—1-30—M. & T.—250 Bks.

E 56919 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56919

CERTIFICATE OF DEATH.

90

15-60

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3306 Tioga Parkway ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Jacobi

(a) RESIDENCE NO. 3306 Tioga Parkway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Jacobi

6 DATE OF BIRTH (month, day, and year) Aug. 9th. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Heineman Rothschild

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jeannette Plaut

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Jacobi (Address) 3306 Tioga Parkway

15 May 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to May 5, 1930, that I last saw her alive on May 5, 1930, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio - sclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms

(Signed) J. D. Shemwell, M. D.

May 6, 1930 (Address) 3310 Tioga Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem.

DATE OF BURIAL 5/8/ 1930

20 UNDERTAKER Harid Sondheim

ADDRESS 118-20-W.-Mt. Royal Ave.

Spec.—1-10-21—M&T—1500 Bks.

E 56920 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56920

CERTIFICATE OF DEATH.

131

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (NO. 25-12 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Hattie Wiener

(a) RESIDENCE NO. St. Agnes Hospital ST., WARD St. Mary's Dale

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adolph Wiener

6 DATE OF BIRTH (month, day, and year): Apr. 17, 1873

7 AGE: Years 57 Months 0 Days 19 If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 31

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cumberland Md.

PARENTS

10 NAME OF FATHER: Simon Sonneborn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Belle Bertheim

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Hospital.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

Mar 1944

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-6- 1930

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1930, to May 6, 1930, that I last saw h-r alive on May 6, 1930, and that death occurred, on the date stated above, at 4 PM m.

The CAUSE OF DEATH* was as follows:

Pyelitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) George Brunner, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oheb Shalom Cem.

DATE OF BURIAL: 5/8/1930

20 UNDERTAKER: David Sondheim

ADDRESS 1520 N. Eut. Royal Va

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56921 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56921

CERTIFICATE OF DEATH.

58-08

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1004 N. CALVERT ST. 11-15 (WARD)

2-FULL NAME SOPHIA RIDGELY HAUGHTON

(a) RESIDENCE NO. 1004 N CALVERT ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	WHITE	WIDOW

5a If married, widowed, ~~divorced~~ (or) WIFE of HENRY OSBURNE HAUGHTON

6 DATE OF BIRTH (month, day, and year) JANY. 2ND 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) BALTIMORE (State or country) MD

PARENTS

10 NAME OF FATHER FRANCIS WEST FLECKS

11 BIRTHPLACE OF FATHER (city or town) BALTIMORE (State or country) MD

12 MAIDEN NAME OF MOTHER MARY ELIZABETH McELDERRY

13 BIRTHPLACE OF MOTHER (city or town) (State or country) CHARLES COUNTY MD

14 Informant H. L. HAUGHTON (Address) 1004 N CALVERT ST BALTIMORE MD

15 Filed MAY 7 1930 19 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, to May 6 30, that I last saw her alive on May 6 30, and that death occurred, on the date stated above, at 9-30 A m.

The CAUSE OF DEATH* was as follows: Pernicious Anemia Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Cause of findings

What test confirmed diagnosis?

(Signed) ....., M. D.

, 19 (Address) 145 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem

DATE OF BURIAL May 8 1930

20 UNDERTAKER Henry Wenkins Sons Co

ADDRESS McCulloh & Eutaw Sts

Spec.—1-30—M. & T.—250 Bks.

E 56922 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56922

47

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Walbert Apts ST. 12-20 (WARD)

2-FULL NAME Rebecca Gaither Myers.

(a) RESIDENCE NO. Walbert apts ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Myers

6 DATE OF BIRTH (month, day, and year) Apr 24-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	—	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer 0

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Chandler Price Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D. C.

12 MAIDEN NAME OF MOTHER Henrietta Gaither

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Matilda F. McComas

(Address) Roland Park Apts.

Filed May 7 1930, 19 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug, 1927, to May 6, 1930,

that I last saw her alive on May 6, 1930,

and that death occurred, on the date stated above, at 7.30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lungs.
Metastasis from
Breast

(duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) W. H. Hoyd, M. D.

, 19 (Address) 140 St. Paul Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem

DATE OF BURIAL May 8 1930

UNDERTAKER Henry H. Jenkins Sons & Orchard

ADDRESS McCulloh

Spec.—1-30—M. & T.—250 Bks.

Dr Van Kirk 1192 Milton Ave Wolf 3930 ✓
Leave at

E 56923 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56923

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO.) 209 N. Fulton Ave (ST.) 4-27 (WARD)

2-FULL NAME John G. Dawnie

(a) RESIDENCE NO. 209 N. Fulton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Margaret G. Dawnie

6 DATE OF BIRTH (month, day, and year) June 2nd 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	11	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Mast
(c) Name of employer Kingan & Co

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS
10 NAME OF FATHER David Dawnie
11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Margaret G. Dawnie
(Address) 209 N. Fulton Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar
Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 3rd, 1930, to May 6th, 1930; that I last saw h[illegible] alive on May 6th, 1930; and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) 1 yrs. ..... mos ..... ds.
CONTRIBUTORY (Secondary) Hypertension Heart
(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) H. J. Tauber, M. D.
, 19 (Address) 1119 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery — DATE OF BURIAL 5/10/1930
20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

5/7 1930

Spec.—1-30—M. & T.—250 Blks.

E 56924 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4975 Dunmore St. 27-5 73 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. S. Thomas

(a) RESIDENCE No. 4975 Dunmore ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Knight Thomas

6 DATE OF BIRTH (month, day, and year) Feb 10 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56.	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER James J Swain

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Stevenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant James W Swain

(Address) 4975 Dunmore ave

Filed 7 1930. 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1930

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1929 to May 6th 1930,

that I last saw her alive on May 6th 1930,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Amyotrophic Lateral Sclerosis

(duration) — yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Clinical Exam.

(Signed) C. H. Jones, M. D.

5-6, 1930 (Address) 4926 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft. Lincoln Cem. DATE OF BURIAL May 8 1930

UNDERTAKER John O. Mitchell Sons ADDRESS 1900 Eastern Ave

Spec.—1-30—M. & T.—250 Bks.

E 56925

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56925

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 202 Lambeth Road (WARD) 12-49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hettie Lumsden Rudd.

(a) RESIDENCE NO. 202 Lambeth Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm D. Rudd

6 DATE OF BIRTH (month, day, and year) Mch 4 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86.	2	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not Any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N C

PARENTS

10 NAME OF FATHER James D. Lumsden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Elmira Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant (Address) Mrs. Myra R. Daulsbury 202 Lambeth Rd

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1930

17 I HEREBY CERTIFY, That I attended deceased from , 1927 to May 7 , 1930, that I last saw h[illegible] alive on May 6 , 1930, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) Some yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos M Cooke, M. D.

5/7, 1930 (Address) 1285 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampton Va

DATE OF BURIAL May 8 1930

20 UNDERTAKER John A. Whitehead and Son

ADDRESS 190 Eutaw Place

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56926 E 56926

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals 46-32 REGISTERED NO.

CITY OF BALTIMORE: (NO. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Dawes

(a) RESIDENCE NO. none ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER John Dawes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Virginia Cloudsey

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed MAY 8 - 1930 Registrar HAMPSON JONES, M. D.

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-7-30

17 I HEREBY CERTIFY, That I attended deceased from 11-15-26, 19..., to 5-7-30, 19...,

that I last saw h... im alive on 5-7-30, 19...,

and that death occurred, on the date stated above, at 11 A.M. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) over 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension (duration) over 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. H. McLean, M. D.

5-7, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL May 9 1930

UNDERTAKER George L. Schwab ADDRESS 208 Fulton Ave.

Cor.—10-10-29—A Co.—100 Bkz.

56927

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 S E 56927

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4704 Charleston St. Curtis Bay 25-77 (Ward)

2-FULL NAME Jacob Franklin.

(a) RESIDENCE NO. 4704 Charleston St. Curtis Bay. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) October 5, 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	87	7	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Franklin.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Sarah Royster.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Harvey J. Franklin. (cousin)
(Address) 4704 Charleston St. Curtis Bay

15 Filed ..... 194.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis: Inquiry
(Signed) Otto M. Reinhardt, M. D.
5/6, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery DATE OF BURIAL May 8 1930

20 UNDERTAKER George L. Schwartz & Bro. ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 56928

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56928

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 24 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Truman

(a) RESIDENCE NO. 616 N. Bond ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence

6 DATE OF BIRTH (month, day, and year) Nov. 16, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Levi Truman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address)

Filed MAY 8 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4-30

17

I HEREBY CERTIFY, That I attended deceased from 3-27, 1930, to 5-4, 1930, that I last saw him alive on 5-4, 1930, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Oesophageal obstruction - probably carcinoma -

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of 4-28-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Lumpkin, M. D.

5-4, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL May 8, 1930

20 UNDERTAKER John J. Kelley Sons — ADDRESS 1318 Light St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56929

CERTIFICATE OF DEATH

38 ✓

E 56929 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1B.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 7-13 Ward)

2-FULL NAME Anizander Williams

(a) RESIDENCE NO. 818 N. Bond St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 7/29

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
		5	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Anizander Williams

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Eula Williams

13 BIRTHPLACE OF MOTHER (city or town) N.C.
(State or country)

14 Informant Eula Williams
(Address) 818 N. Bond St

15 Filed MAY 8 - 1930 HARRY JONES M Registrar
By R P K

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6/30 '92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY Congenital Heues
(Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

5/7/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cemetery

DATE OF BURIAL May 8 1930

20 UNDERTAKER Robert T Williams 1515 McElderry

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56930

CERTIFICATE OF DEATH

3/V E 56930

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No.) Rear 1825 Madison St. 14-20 Ward

2-FULL NAME Emma J. Fuller.

(a) RESIDENCE NO. 1824 Madison St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem
4 Color or Race: Col
5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 9-14-16

7 AGE: Years 14 | Months 2 | Days 18 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Ga.
(State or country)

PARENTS

10 NAME OF FATHER: Henry Fuller

11 BIRTHPLACE OF FATHER (city or town): Ga.
(State or country)

12 MAIDEN NAME OF MOTHER: Ada Williams

13 BIRTHPLACE OF MOTHER (city or town): Ga.
(State or country)

14 Informant: Henry Fuller
(Address): 1824 Madison

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 6 - 1930

17 I HEREBY CERTIFY That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) ..... M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cem

DATE OF BURIAL: May 10 1930

20 UNDERTAKER: Robert Williams

ADDRESS: 1515 McElderry St

Important. See instructions on back of certificate.

Spec.—3-29-28—L. F. S.—500 Bks.

E 56931

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56931

CERTIFICATE OF DEATH

111-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 Light St. 24-35 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Matilda A Trumbo

(a) RESIDENCE NO. 1415 Light ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 1 mos. 7 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	W	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew J Trumbo

6 DATE OF BIRTH (month, day, and year) March 28/854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John F. Say

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Irvin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr Andrew J Trumbo

(Address) 1415 Light St

15 Filed MAY 8 1930 C. HAMPSON JONES, M. D. Registrar Roc

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5/1930

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1930, to May 5, 1930, that I last saw her alive on May 5, 1930 and that death occurred, on the date stated above, at 10 40 P. m.

The CAUSE OF DEATH* was as follows:

Abscess of the liver and Ulcerated stomach

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Valvular heart disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

5/7, 1930 (Address) 1215 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL May 8 1930

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

Spec.—1-30—M. & T.—250 Blks.

56932 E 56932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH Baltimore City Hospitals ST. 19-26 WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Lee Kang (Kang)

(a) RESIDENCE NO. 1804 Frederick Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Chinese	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) China

PARENTS

10 NAME OF FATHER Lee Kneu

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Chin See

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant Records of B. C. H.

(Address)

15 Filed 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6-30

17 I HEREBY CERTIFY, That I attended deceased from 5-6-30, 19, to 5-6-30, 19,

that I last saw him alive on 5-6-30, 19,

and that death occurred, on the date stated above, at 8-30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 5 mos da.

CONTRIBUTORY (Secondary) Gangrene of Legs: Hypoarteritis, Chronic (duration) yrs. ? mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical: Sugar tests

(Signed) Warren H. McLane, M. D.

5-7, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL May 9 1930

20 UNDERTAKER John P. Deems

ADDRESS 715 Light St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56933

CERTIFICATE OF DEATH

185 E 56933

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hurwin Memorial Hospital St. (Ward)

2-FULL NAME Nancy Dickinson

(a) RESIDENCE NO. 407 N. Hilldrop St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 14 1928

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	2.		22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Zeltz Ind
(State or country)

PARENTS

10 NAME OF FATHER Chas Dickinson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Thomas Freyer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ind

14 Informant Chas Dickinson
(Address) 407 N. Hilldrop

15 Filed May 8 1930 C. HAMPSON JONES, M. D. Registrar
By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to her death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:
Head Injury (by falling) accidental fall (Fall).
Possible Intracranial Hemorrhage (duration) ....yrs. ....mos. ....ds.

over

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Morrison, M. D.

5/7 1930 (Address) 7672 Aland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 8 1930
20 UNDERTAKER	ADDRESS
Lee Cook	1217 N. Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

56934

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56934

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Harter

(a) RESIDENCE NO. Chester Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Viola Harter

6 DATE OF BIRTH (month, day, and year) March 12-1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work State policeman 061

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Curtis Harter

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Mary E. Thomas

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Angie V Harter

(Address) Chester Maryland

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-7-30

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to May 7, 1930, that I last saw him alive on May 7, 1930, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with hypertension

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure (congestive)

(duration) yrs. 14 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Physical signs

(Signed) W. H. Varney, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Christiana Md

DATE OF BURIAL 5/8/ 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Y 8 - 1930 HAR ROK

Registrar

Cor.—1-12-28—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56935

E 56935

CERTIFICATE OF DEATH.

REGISTERED NO. 188-103

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Genl Hosp ST., 12-50 WARD)

2-FULL NAME John Dick Halliday Jr.

(a) RESIDENCE NO. 2605-N-Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 6 mos. 15 ds. How long in U. S., if of foreign birth? 21 yrs. 6 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) October-22-1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	6	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer) Dealer
(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John D. Halliday

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophy Sadtler

13 BIRTHPLACE OF MOTHER (city or town) Balto Co. (State or country) Maryland

14 Informant Mrs Sophy S. Halliday (mother) (Address) 2605-N-Charles St

15 Filed ....., 192.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-7-30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto in which he was a rider overturned Crushing his pelvis

(Duration) Fract Pelvis - Severe

CONTRIBUTORY (Secondary) Lacer of perineum & bladder (Duration) yrs. mos. ds.

(Signed) S. Frank M. D. (Coroner.)

5/8, 1930 (Address) 3939 W. Belvedere

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) At place of death 0 yrs., 0 mos., 7 days. In the State 21 yrs., 6 mos., 15 ds.

Where was disease contracted, if not at place of death? Automobile Accident U. G. G. Md.

Former or usual residence Marley Creek Road 2605-N-Charles St

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery DATE OF BURIAL May 19 1930

20 UNDERTAKER Stewart & Co ADDRESS Balto

H. HANSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 E 56936

E 56936

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. 1721-Park-Av. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Everett Clark

(a) RESIDENCE NO. 1721-Park-Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 0 ds. How long in U. S., If foreign birth 84 yrs. 4 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Emma Clark

6 DATE OF BIRTH (month, day, and year) Dec-25-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER John F. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Rebecca Everett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mr. Chas. B. Clark-Son

(Address) 1721-Park-Av.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 30

17 I HEREBY CERTIFY, That I attended deceased from Jan ....., 19 28, to May 6 ....., 19 30.

That I last saw ~~him~~ alive on May 6 ....., 19 30.

and that death occurred, on the date stated above, at 10-P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Mitral Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. H. Worthy, M. D.

19 (Address) 140 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	May 8th 1930
20 UNDERTAKER	ADDRESS
Stewart & Moren Co	Balto.

MAY 8 - 1930 HERMAN JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

56937

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56937

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816-N-Dallas- ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Campbell

(a) RESIDENCE NO. 1816-N-Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 8 mos. 12 ds. How long in U. S., if foreign birth? 83 yrs. 8 mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Campbell

6 DATE OF BIRTH (month, day, and year): Aug-25-1846

7 AGE — Years: 83 | Months: 8 | Days: 12 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Eichelberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): York Pennsylvania

12 MAIDEN NAME OF MOTHER: Elizabeth Glasco

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs Mabel Thomas (daughter)

(Address) 1816-N-Dallas-St

FILED MAY 8 - 1930 H. LEE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23 -, 19..., to May 7 -, 1930, that I last saw h.. alive on May 6 -, 1930 and that death occurred, on the date stated above, at 3:10 a. m.

The CAUSE OF DEATH* was as follows:

Left hemiplegia

Hemorrage

(duration) — yrs. 2 mos. 15 da.

CONTRIBUTORY (Secondary): Bed sores

(duration) — yrs. 1 mos. 10 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

5/7/1930 (Address) 223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: May 9 1930

20 UNDERTAKER: Stewart Mortuary Co — ADDRESS: Dallas

Spec.—8-16-29—L. F. S.—100 Bks.

236586 Lutz E 56938 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 124 E 56938

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-13 WARD)

2—FULL NAME Mrs. Jennie Peretz

(a) RESIDENCE NO. 1843 No. Gay ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9, 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Cyrus Rhoades

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Louise Wertz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 8-8 1930 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 6 '30

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 6, 1930, that I last saw h.e.r. alive on May 6, 1930 and that death occurred, on the date stated above, at 9 20 p. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary embolus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 4

Was there an autopsy? Yes Diagnosis

What test confirmed diagnosis?

(Signed) I. R. Trimble, M. D.

May 7 1930 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	May 9 1930
20 UNDERTAKER Henry Lutz	ADDRESS 1203 Broadway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 E 56939

CERTIFICATE OF DEATH.

E 56939

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Aves ST. 20-28 (WARD)

2-FULL NAME Morris Cushner

(a) RESIDENCE NO. 2020 Wilkens Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Cushner

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Sadie Cushner

(Address) 2020 Wilkens Ave.

15 Filed MAY 8 - 1930 Registrar C. HARRY JONES, M. D.

Per RUR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-7 1930 Daylight Saving T.

17 I HEREBY CERTIFY, That I attended deceased from 5-4 , 1930 , to 5-7 , 1930 .

that I last saw h[illegible] alive on 5-7 , 1930 ,

and that death occurred, on the date stated above, at 7-P[illegible] m. EST.

The CAUSE OF DEATH* was as follows: Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Brenner, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Wash Road

DATE OF BURIAL 5-8 1930

UNDERTAKER Jack Levine 1739 E.

ADDRESS Balto St.

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56940 90 E 56940

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3700 Cottage Ave. St.) 15-58 (WARD)

2-FULL NAME Etta Dora Smith

(a) RESIDENCE NO. 3700 Cottage Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Solomon Smith

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Taba Galdsworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lewis (Address) 1439 E Balto St.

15 Filed ..... 19 ..... HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 7, 1930, that I last saw her alive on May 7, 1930, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Myocarditis

(duration) Finally

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ..... M. D.

5/8, 1930 (Address) 2040 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lakewood

DATE OF BURIAL 5-8- 1930

20 UNDERTAKER Jack Lewis 1439

ADDRESS E Balto

Cor.—10-10-29—A Co.—100 Bks.

E 56941

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 56941

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 10-14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua Swann

(a) RESIDENCE NO. 1213 Ashland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence In city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Fannie Swann

6 DATE OF BIRTH (month, day, and year) Nov. 1896

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
33	4		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER Joshua Swann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ella Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md

14 Informant Gussie Banks
(Address) 1213 Ashland Ave

15 Filed ....., 19.. L. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry find that said deceased came to death (autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. da.

18 Where was disease contracted — If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) J C & Cadle, M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lamel Cemetery — DATE OF BURIAL 5/9 1930

20 UNDERTAKER Franklin West — ADDRESS 709 W 33rd St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 2-29-28—L. F. S.—500 Blks.

E 56942

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56942

CERTIFICATE OF DEATH

REGISTERED NO. 44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 Ashland Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Martha Jane Miller

(a) RESIDENCE NO. 1100 Ashland Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Horace Miller

6 DATE OF BIRTH (month, day, and year): Sept 3 1870

7 AGE: Years 59 | Months 8 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Harriet Deaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Prof. H. Miller

(Address) 1231 Bolton Baltimore, Md

15 Filed MAY 8 1930, 19 BY HAMPSON, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/6/30

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1930, to May 6th, 1930

that I last saw h[illegible] alive on May 6th 1930

and that death occurred, on the date stated above, at 4:05 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Symptomatology

(Signed) A. S. Del Dell, M. D.

, 19 (Address) 713 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary

DATE OF BURIAL: May 8, 1930

20 UNDERTAKER: Mrs. Ida Saunders

ADDRESS 1208 E. Madison

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56943

E 56943

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen'l Hosp. WARD 12)

2-FULL NAME Mrs Annie Walter

(a) RESIDENCE NO. 2214 E. Chase St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Walter

6 DATE OF BIRTH (month, day, and year) 7/31/1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	66	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Heinrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Jaster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Husband Present (Address)

15 Filed MAY 8 - 1930, 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1930

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1930, to May 6, 1930, that I last saw h alive on May 4, 1930, and that death occurred, on the date stated above, at 10:03 P. m. S.T.

The CAUSE OF DEATH* was as follows:

Acute Cystitis Media

Chronic myocarditis

(duration) yrs ? mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

5/7/30 (Signed) [illegible] M. D.

(Address) [illegible] Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Michael's Cem Perry Hall md.

DATE OF BURIAL May 9, 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Aisquith St

CAUSE OF DEATH must be stated plainly, so that a layman can understand it. See instructions on back of certificates. TION is very important.

C. HERBERT JONES, Registrar

Cor.—10-10-29—A Co.—100 Bks.

E 56944

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56944

CERTIFICATE OF DEATH

187-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Sharp & Dohme

City of Baltimore: (No. Howard & Pratt St., 1-3 Ward)

2-FULL NAME Carrie Diesel

(a) RESIDENCE NO. 806 S. Kenwood Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph C. Diesel

6 DATE OF BIRTH (month, day and year) March 4-1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	58	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Char-woman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Sharp & Dohme

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Rickert

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret ——

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Geo. C. Diesel (Son)
(Address) 806 S. Kenwood Ave

15 Filed ....., 19.... HAMPSON JONES M.D. Registrar

MAY 8 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 5- 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to crushing wounds of head & chest. Fell into elevator shaft. Accidental death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination.

(Signed) Eugene Krebs, M. D.

5/7. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartzo Cem.

DATE OF BURIAL May 8 1930

20 UNDERTAKER Philip Herring

ADDRESS 2516 Orleans

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 56945 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56945

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Riggs Ave WARD) 16-22

2-FULL NAME Jennie Gatewood

(a) RESIDENCE NO. 1704 Riggs Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	col	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Armistead Gatewood

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
51				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Mc Graw Va

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Richd. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Armistead Gatewood

(Address) 1704 Riggs Ave

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1930

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to May 6, 1930, that I last saw her alive on May 6, 1930 and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Shedlin, M. D.

May 6, 1930 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 5-8 1930

UNDERTAKER Edward Carter

ADDRESS 916 Dade

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 56946

E 56946 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) 939 W Lexington St (Ward) 16

2. FULL NAME Benjamin Scott

(a) RESIDENCE NO. 939 W Lexington St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jas Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Jas Scott

(Address) 939 W Lexington St

15 Filed ..... 19 ..... Registrar

G. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6-1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1930, to May 6, 1930, that I last saw h— alive on May 6, 1930, and that death occurred, on the date stated above, at 6.30 P a.m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Chronic Pyelitis

(duration) yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam Etc

(Signed) Chas Norton M. D.

5/6, 1930 (Address) 888 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 5-8 1930

20 UNDERTAKER David Carson

ADDRESS 916 Pa ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56947

3E 56947

CERTIFICATE OF DEATH

188-103

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Balto City Hosp 26-37

City of Baltimore: (No. St., Ward)

2-FULL NAME Frank R Dorn

(a) RESIDENCE NO. 6800 Eastern Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Dorn

6 DATE OF BIRTH (month, day, and year) Sept 29-1860

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	69	7	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) Anchor Fence Wks
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Frank Dorn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Marsha Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Lena Dorn Wife
(Address) 6800 Eastern ave

Filed ... 19... C. HAMPSON ... M. D.
No. ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:
Struck & knocked down by moving auto while crossing road

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Eastern Ave & Dundalk

Did an operation precede death? no Date of Lumbar P.

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. J. Hamm, M. D.

5-8 1930 (Address) 2934 Ms Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem May 8 1930

DATE OF BURIAL

20 UNDERTAKER Lillie Zeiler

ADDRESS 1403 Dolphin St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56948

CERTIFICATE OF DEATH.

100-201

E 56948

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 805 Eaton Ave ST. 9-47 WARD)

2-FULL NAME Alma Carolyn Thomas

(a) RESIDENCE NO. 805 Eaton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1-1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER W. Raymond Thomas

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Dietz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant W. Raymond Thomas
(Address) 805 Eaton Ave

15 Filed 8-1930 C. HAMPSON MILLS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7-1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 28, 1930, to May 7, 1930,

that I last saw her alive on May 7, 1930,

and that death occurred, on the date stated above, at 5-40 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute diffuse Bronchitis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Gustav Th Volkmann, M. D.

May 7, 1930 (Address) 1120 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL May 8th 1930

20 UNDERTAKER Lilly + Zeiler Sue ADDRESS 403 S. Wolfe St

1-30—M. & T.—100 B—50L

E.5-6949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-00 E. 5-6949

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospital ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Mr. John Davis

(a) RESIDENCE NO. 1514 Thames St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 27, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Evans Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Susanne------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 1930 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 30 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. mos — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What was confirmed diagnosis?

(Signed) M. D. Coroner

19 (Address) 1432 E Biddy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL MAY 9 19 30

20 UNDERTAKER

ADDRESS

C. HAMILTON JONES, M.D. COMMISSIONER OF HEALTH.

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56950

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56950

118-80

CERTIFICATE OF DEATH

1—PLACE OF DEATH Church Home + Infirmary

REGISTERED NO.

CITY OF BALTIMORE: (No. Broadway + Fairmount Ave. WARD) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Oles

(a) RESIDENCE NO. 2732 O'Donnell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced (HUSBAND of (or) ~~WIFE of~~) Apolonia Lena Oles

6 DATE OF BIRTH (month, day, and year) Feb 24 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer — Own Business

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Paul Oles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Apolonia Oles. (Address) 2732 O'Donnell St.

15 Filed ....30.... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1930

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1930, to May 6, 1930, that I last saw h~~im~~ alive on May 6, 1930, and that death occurred, on the date stated above, at 12.50 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

10 minutes (duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....(duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/1/30

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Andrew J. E. Akelaitis, M. D.

, 19 (Address) Church Home + Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem

DATE OF BURIAL 5-10 1930

20 UNDERTAKER Stephen J. Zalkowski Inc

ADDRESS 1001 S. Monroe St

Spec.—1-30—M. & T.—250 Bks.

60

E 56951 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56951

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2518 Brookfield ave ST., 43-59 WARD

2-FULL NAME Benjamin Sussman

(a) RESIDENCE NO. 2518 Brookfield ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose

6 DATE OF BIRTH (month, day, and year) Ushnow

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Louis Sussman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Chyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant S. Sussman (Address) 2519 Brookfield ave

15 Filed ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7/30

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 8, 1930, that I last saw him alive on May 7, 1930, and that death occurred, on the date stated above, at 11.20 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardio-vascular-renal disease

Pulmonary Fibrosis

several years (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. Allen Sussman M. D.

5/8, 1930 (Address) 2340 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sinai Rosedale

DATE OF BURIAL 5/10 1930

UNDERTAKER Sol Levinson 1330

ADDRESS 1127 E Baltimore st

[illegible] C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

E 56952

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56952

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 Gang ST., 17th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bettie Jones

(a) RESIDENCE NO. 731 Gang ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Laurel Md

PARENTS

10 NAME OF FATHER Daniel Oakes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucinda ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Rosa Fletcher

(Address) 731 Gang St

15 Filed MAY 8 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to May 5, 1930, that I last saw h... alive on May 5, 1930, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 19

20 UNDERTAKER Paul L Hensley

ADDRESS 576 N Bidle

REGISTRAR'S OFFICE ST. LOUIS, MO.

Spec.—1-30—M. & T.—250 Bks.

E 56953 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56953

CERTIFICATE OF DEATH. 31

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 18-26 (AND)

CITY OF BALTIMORE: (NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Foreman

(a) RESIDENCE NO. 113 N. Carlton st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Foreman

6 DATE OF BIRTH (month, day, and year) Dec 27 188?

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	40	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Banks

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellenora Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Samuel Foreman

(Address) 113 N. Carlton st

Filed 5-7-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 7, 1930, that I last saw her alive on May 7, 1930, and that death occurred, on the date stated above, at 5.10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

19 months (duration) 1 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Turner Jr. M. D.

5-7, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	May 10 1930

20 UNDERTAKER Joseph A. Lively ADDRESS 409 N. Mount St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56954

CERTIFICATE OF DEATH

36-41

E 56954

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4405 Valleyview Ave St., Ward)

2-FULL NAME Vincent Lebeda

(a) RESIDENCE NO. 4405 Valleyview Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Alen Capsute

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B & O R R

9 BIRTHPLACE (city or town)
(State or country) Lithuania

PARENTS

10 NAME OF FATHER Peter Lebeda

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Alen Lebrda WIFE
(Address) 4405 Valleyview Ave

15 Filed ..., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pistol Shot Wound in rt temple
Suicide

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)
(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature], M. D.
5/8/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 10, 1930
20 UNDERTAKER	ADDRESS
John Grebliauckas	423 S Paca St

Spec.—8-16-29—L. F. S.—100 Bks.

E 56955 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56955

CERTIFICATE OF DEATH X 132

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Church Home and Infirmary STREET 6-9 WARD)

2—FULL NAME Emory E. Dayhoff.

(a) RESIDENCE NO. Woodbine, Carroll County, Maryland WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-21-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer (retired)

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER James A. Dayhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Libbie Garner.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Ervitt Dayhoff
(Address) Catonsville Md.

15 Filed MAY 8 1930 16 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8-30

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1930, to May 8, 1930, that I last saw him alive on May 8, 1930 and that death occurred, on the date stated above, at 7:15 A. m.

The CAUSE OF DEATH* was as follows:

Nephrolithiasis; with severe hemorrhage

(duration) yrs. Six mos. da.

CONTRIBUTORY (Secondary) Uremia; with pulmonary oedema (duration) yrs. mos. Four ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms

(Signed) Leon B. Wallace M. D.

, 19 (Address) Church Home Infir.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Locust Grove Cemetery — DATE OF BURIAL May 11, 1930

20 UNDERTAKER C. M. Mattz, Winfield, Md. — ADDRESS

Important. See instructions on back of certificate

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56956

CERTIFICATE OF DEATH.

90 E 56956

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1901 N. Wolfe St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Schultz

(a) RESIDENCE NO. 1901 N. Wolfe St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a ~~If married, widowed, or divorced~~ HUSBAND of (or ~~WIFE of~~): Mary C. Schuman

6 DATE OF BIRTH (month, day, and year): [illegible] 1847

7 AGE: Years 82 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant: Clara Bush

(Address) 1901 N. Wolfe St.

15 Filed MAY 8 - 1930 CHAMPE SAYRES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1 1930 to May 7, 1930, that I last saw h[illegible] alive on May 7, 1930, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical course

(Signed) Adam Schultz, M. D.

5/5, 1930 (Address) 1902 Hatton Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

Date of Burial 5/10 1930

20 UNDERTAKER: J. Foley Ward

ADDRESS 131 E. Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 56957

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56957

CERTIFICATE OF DEATH.

Registered No. 1565

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2502 Harrison ave St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Demarest

(a) Residence No. 2502 Harrison ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Sylvester Demarest

6-DATE OF BIRTH (month, day and year): June 3 1857

7-AGE: 73 yrs. 11 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9-BIRTHPLACE (city or town) (State or Country): Franklin Lakes N. J.

PARENTS.

10-NAME OF FATHER: Albert Blauvelt

11-BIRTHPLACE OF FATHER (city or town) (State or Country): N. J.

12-MAIDEN NAME OF MOTHER: Marie Gabrielsen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): N. J.

14- (Informant): Mrs Alvin Ebers

(Address): 2502 Harrison ave

15- Filed ... 1930 C. HAMPSON JONES, M. D. 192 Per ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 7 1930

17- I HEREBY CERTIFY, That I attended deceased from Sept., 1929 to May 7, 1930, that I last saw h[illegible] alive on May 6 1930 and that death occurred, on the date stated above, at 12.40 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) George M. Gayle M. D.

5/7, 1930 (Address) 1245 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Hackettstown N. J. DATE OF BURIAL, May 8 1930

20-UNDERTAKER: W. J. Tuckey & Son ADDRESS N. Pa ave

Instructions on back of certificate.

Spec.—1-10-21—M&T—1506 Bks.

E56958. E56958

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Edward Ehrman

(a) RESIDENCE NO. 435 E. 28th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Ann Colton

6 DATE OF BIRTH (month, day, and year) 11/1/1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mgr. of

(b) General nature of industry, business, or establishment in which employed (or employer) Lewis & Ehrman Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Lewis Ehrman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia Gronau

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Hospital record. (Address)

15 Filed May 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1930

17 I HEREBY CERTIFY, That I attended deceased from April 27 1930 to May 6 1930, that I last saw h[illegible] alive on May 6 1930, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

Gastric Varicosity

(duration) 30? yrs. mos. ds.

CONTRIBUTORY (Secondary) Delirium Tremens. Gastric hemorrhage (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

(Address) [signature]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL May 9 1930

20 UNDERTAKER Henry W. Meard & Son

ADDRESS 805 N. Calvert St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information of cause of death is very important. See instructions on back of certificates.

MAY 9 - 1930

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56959

CERTIFICATE OF DEATH.

129 E 56959

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2725 Huntington Ave. Ward 12-51)

2-FULL NAME George T. Sigler

(a) RESIDENCE NO. 2725 Huntington Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret J. Sigler

6 DATE OF BIRTH (month, day, and year) Sept 20. 1853

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	76	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer) 019

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Cumberland Md

PARENTS

10 NAME OF FATHER Wesley Sigler

11 BIRTHPLACE OF FATHER (city or town) Hillendown

(State or country)

12 MAIDEN NAME OF MOTHER Charity Duckworth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Margaret J. Sigler

(Address) 2725 Huntington Ave

C. HAMPSON JONES, M. D.

Registrar

8 1930 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1930, to May 7, 1930, that I last saw him alive on May 6, 1930, and that death occurred, on the date stated above, at ..... A.m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis (duration) 10 yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. T. Zimmerman, M. D.

May 7 1931 (Address) 1858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Date of Burial May 10, 1930

20 UNDERTAKER Mr & Mrs. J. W. Funkel & Son ADDRESS 801 W. Fayette

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56960 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56960

CERTIFICATE OF DEATH.

129

REGISTERED NO. H-68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2504 N Lafayette Av ST., H-68

2-FULL NAME Charles Siegfried.

(a) RESIDENCE NO. 2504 N Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced.

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 9 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany.

14 Informant Mrs John Ernst (Daughter)

(Address) 2504 N. Lafayette Ave

Filed 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6-1930

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1930, to May, 1930,

that I last saw h[illegible] alive on May 6, 1930,

and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos da.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? None Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Chas W. Hemmeter, M. D.

May 7, 1930 (Address) 3002 Gaswick Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk

DATE OF BURIAL 5-9th 1930

UNDERTAKER Thos Chas A G Robbe

ADDRESS 2327 Edmondson Ave

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56961 (2964) 30

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 56961

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Frank Rosenberg

(a) RESIDENCE NO. Hotel Belvedere ST., WARD HPPC. East 4

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Simon Rosenberg

6 DATE OF BIRTH (month, day, and year): January 26, 1857

7 AGE: Years 73 | Months 3 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: none

(a) Trade, profession or particular kind of work: [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Abraham Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sarah Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

11 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 Filed [illegible] 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1930, to May 7, 1930, that I last saw her alive on May 7, 1930, and that death occurred, on the date stated above, at 10.25 p.m.

The CAUSE OF DEATH* was as follows:

Hypernephroma with cerebral metastases

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Acute endocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Ruth E Fairbank, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sinai Hebrew Cem.

DATE OF BURIAL: 5/9/1930

20 UNDERTAKER: David Sondheim

ADDRESS: 110-20 W. Mt. Royal ave

Important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 56962

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1882 E 56962

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 m. J Pier 4 Balt St-b ST., WARD)

2-FULL NAME (McMenon (Rda)

(a) RESIDENCE NO 1 McMenon ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....

(Address)

15 Filed MAY 8 - 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Ten death on the day stated above.

The CAUSE OF DEATH* was as follows:

Trauma (Accidental)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) L. T. Ely, M. D. Coroner

May 3, 19 30 (Address) 1638 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS MAY 8 - 1930

THE MORGUE

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56963

CERTIFICATE OF DEATH

168 E 56963

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 720 S Wolfe St. 2-4 Ward)

2-FULL NAME John Schab

(a) RESIDENCE NO. 2009 Portugal Street St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or WIFE of)~~ Honorata Schab

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER John Schab

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Agnes Kurgan

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Honorata Schab
(Address) 2009 Portugal st

15 Filed 19 (Registrar)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Hanging

(duration) yrs. mos. 4hrs

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? — —

What lesions were found? —

May 8 1930

(Signed) G C Wade, M. D.

, 19 (Address) 1431 B Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St, Stanislaus Cem,.	May 8th 30 19
20 UNDERTAKER George A. Weber	ADDRESS 705 S Ann

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

8 - 1930 C. HAMPSON JONES, M. D.

Mar Ret

Spec.—8-16-29—L. F. S.—100 Bks.

236256 E 56964

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56964

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John L. Baker

(a) RESIDENCE NO. Columbus Ohio ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edith S. Baker

6 DATE OF BIRTH (month, day, and year): July 27-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate Dealer

(b) General nature of industry, business, or establishment in which employed (or employer):

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: Wm Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Ida Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 8-1930 C. HAMPSON JONES, M. Registrar

Per NKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May-7-1930

17

I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to May 7, 1930, that I last saw him alive on May 7, 1930 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor - Benign

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

5/7, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Columbus, Ohio	May 8, 1930
20 UNDERTAKER: Cook & Cook	ADDRESS: 603 N. Eutaw

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56965

CERTIFICATE OF DEATH

74-901

E 56965

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) En route to University Hospital St., Ward 19-46

2-FULL NAME Robert Lee Osborne

(a) RESIDENCE NO. 1126 Homestead St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amanda Osborne

6 DATE OF BIRTH (month, day, and year) March 6-1892

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Police-man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto. City 061

9 BIRTHPLACE (city or town)
(State or country) Mo.

PARENTS

10 NAME OF FATHER George S. Osborne

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Alice Hardigan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Cal.

14 Informant Mrs. A. Osborne
(Address) 1126 Homestead St.

15 [illegible] 19 30 Registrar [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7- 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fuller, M. D.

19 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

20 UNDERTAKER [illegible]

DATE OF BURIAL May 10 1930

ADDRESS 2238 W Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 56966

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 E 56966

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 105 Broad Alley ST. 5-8 (WARD) Silver

2-FULL NAME Oscar (Delaware)

(a) RESIDENCE No. 105 Broad Alley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	M-

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Amelia Dilver

6 DATE OF BIRTH (month, day, and year) May 5, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O H O
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Shadd Dilver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Harcum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Amelia Harcum

(Address) 1302 Gilmore.

15 5-8-1930 C. HAMPSON JONES, M. D. Registrar

Ret. ....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) C. E. Bladen, M. D. Coroner

, 19 (Address) 143 S. Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cemetery

DATE OF BURIAL may 9 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1393 Pennsylvania Ave

8

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56967

E 56967

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Stmr. Chatham, M & M S/S Co. Ward 17-24

City of Baltimore: (No. Pier 8 Pratt St. St.

2-FULL NAME John Bailey. (C)

(a) RESIDENCE NO. 1207 Myrtle Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Divorced.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Stella Bailey. (C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	48	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Elizabeth Bailey. (C)
(Address) 1207 Myrtle Ave.

15 DATE OF BURIAL 8-1930

C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

5/8, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Mt. Auburn

20 UNDERTAKER Daniel Easton

DATE OF BURIAL 5-8 1930

ADDRESS 516 Dec

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-23—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56968

74-001 V

E 56968

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1335 Hanover (St.) 25-72 (Ward)

2-FULL NAME Joseph Kahler

(a) RESIDENCE NO. 1335 Hanover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Hyronimus Kahler

6 DATE OF BIRTH (month, day, and year) March 15. 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	54	1	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H. W.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Bohemia.
(State or country)

PARENTS

10 NAME OF FATHER Jos. Dvorak

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia

14 Informant Tora F. Reiter
(Address) 5611 Magnolia Av

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar
1930 by

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

a) Apoplexy

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brosius, M. D.

May 7. 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 9 1930
20 UNDERTAKER J. B. Hobbs	ADDRESS 1856 Bush St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8

Spec.—8-16-29—L. F. S.—100 Bks.

E 56969

HEALTH DEPARTMENT—CITY OF BALTIMORE

146

E 56969

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH University Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard & Greene ST., [illegible] WARD)

2—FULL NAME Vattie Brown.

(a) RESIDENCE NO. 1224 N Stricker St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 2 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	7	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER Geo Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Grace Howard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Grace Brown
(Address) 1224 N. Stricker

15 Filed [illegible] 19 [illegible] Registrar.

MAY 9 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/6/30

17 I HEREBY CERTIFY, That I attended deceased from 4/20/30, 19..., to 5/6/30, 19..., that I last saw her alive on 5/6/30, 19... and that death occurred, on the date stated above, at 8 35 A.M. E.S.T.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis
Septicemia
Infected Uterus
Branchopneumonia (duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary) Cervical Dystocia
Caesarian Section (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/26/30

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Clinical.

(Signed) Henry D. [illegible], M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL May 9 1930

20 UNDERTAKER John H. Frazier

ADDRESS 1027 Lund Hill

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56970

CERTIFICATE OF DEATH

66 E 56970

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 410 St Paul St. 47 Ward)

2-FULL NAME Howard Davis

(a) RESIDENCE NO. 410 St Paul St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
male	white	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6, 1887

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
43	42	9	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) Self.
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER C. Davis

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER A. Brown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant C. A. Davis
(Address) 1211 Bryn.

Filed MAY 9 - 1930 HAROLD R. JONES, Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Disturbed May 5 Finished May 6 192 5

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

Last Illness (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. J. Kelly Crowe, M. D.

May 9 1930 (Address) 1637 Bruadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	May 9 1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 56971 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56971

CERTIFICATE OF DEATH.

X 74-001

28-164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3128 Howard Park Ave ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert B. Vaut

(a) RESIDENCE NO. 3128 Howard Park Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Vaut

6 DATE OF BIRTH (month, day, and year) Dec 6. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Draftsman 586

(b) General nature of industry, business, or establishment in which employed (or employer) Mason Hamlin

(c) Name of employer ~~H. H.~~ Boston Mass

9 BIRTHPLACE (city or town) (State or country) Cincinnati Ohio

PARENTS

10 NAME OF FATHER Theodore Vaut

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Teresa Trautwein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles J. Vagt

(Address) 3128 Howard Park Ave

Filed MAY 9 1930. C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8/30.

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, to May 8, 1930,

that I last saw ~~him~~ alive on May 8, 1930,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

Cerebral Hemorrhage

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) G. C. Brumbach, M. D.

May 9, 1930 (Address) 4509 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lutheran Cem Brooklyn N.Y.

DATE OF BURIAL May 12 1930.

UNDERTAKER Mr & Mrs. John N. Teufel & Son

ADDRESS 801 N. Fayette

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56972 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56972

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 16-2238

CITY OF BALTIMORE: (No. ..... ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hezekiah Lawrence

(a) RESIDENCE NO. 1032 N. Stricker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) July 16, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Indies

PARENTS

10 NAME OF FATHER Joseph Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies

12 MAIDEN NAME OF MOTHER Margaret Frances

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Indies

14 Informant Records of

(Address) Baltimore City Hospitals

Filed 5-9-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6-30

17 I HEREBY CERTIFY, That I attended deceased from 4-29-30, 19..., to 5-6-30, 19..., that I last saw him alive on 5-6-30, 19..., and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta with aneurysm

Hemorrhage (duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of -

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy. Wassermann.

(Signed) Paul Padget M. D.

(Address) 5-8-1930 Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart DATE OF BURIAL May 9, 1930

20 UNDERTAKER John J. Bailey Sons ADDRESS 1318 Light St.

Spec.—1-12-23—M&T—500 Blks.

E 56973 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56973

CERTIFICATE OF DEATH. 57

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto General Hosp ST. 28-64 (WARD)

2-FULL NAME Frederick L. Kruse

(a) RESIDENCE NO. 3619 Ferndale Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dora Kruse

6 DATE OF BIRTH (month, day, and year) Feby 23/1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	76	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Orthopedic Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) 0/H

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Kruse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Fenker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Sadie Saunders
(Address) 2515 Garrison Blvd

15 Filed MAY 9 1930 C. HAMPTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8 1930

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1930, to May 8, 1930, that I last saw h[illegible] alive on May 8, 1930, and that death occurred, on the date stated above, at 3:35 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetic coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 4/24/30

Was there an autopsy? no

What test confirmed diagnosis? Clinical & laboratory

(Signed) S A Alessi, M. D.

, 19 (Address) West Balto General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL May 10 1930

20 UNDERTAKER Harry T Annacoot

ADDRESS 4204 Ridgewood Ave

CAUSE OF DEATH must be plainly written, so that it may be read. See instructions on back of certificates. TION is very important.

Y 9 - 1930

Cor.—10-10-29—A Co.—100 Bks.

E 56974

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56974

CERTIFICATE OF DEATH

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 7-13 Ward)

2-FULL NAME Annie Gruenagel

(a) RESIDENCE NO. 1038 N. Dallas St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Adam Gruenagel

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	78			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Peter Rosenberger
(Address) 1323 E. Eager St.

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitis

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Weiss, M. D.

5/9/30 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 10 1930
20 UNDERTAKER	ADDRESS
Henry Koch & Sons Inc	1301 E Eager St

9 1930 C. HARRISON JONES, M. D.

Spec.—6-29-23—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56975

CERTIFICATE OF DEATH

57 V

F 56975

1—PLACE OF DEATH. CITY OF BALTIMORE. (No.) South Baltimore Gen'l Hospital ST. (WARD) 9. REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Betty Friedman

(a) RESIDENCE NO. 220 N. Castle ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 4½ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Friedman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Russia~~ England

PARENTS

10 NAME OF FATHER Isaac Odet

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Anderia

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Jack Lewis

(Address) 1439 E Balto St

15 Filed MAY 9 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-8-30

17. I HEREBY CERTIFY, That I attended deceased from 5-7, 1930, to 5-8, 1930, that I last saw h[illegible] alive on 5-8, 1930 and that death occurred, on the date stated above, at 9:20 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangreous Intestine (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5-8-30

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Joseph Kaufmann M. D.

, 19 (Address) South Baltimore Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Workmen Circle, Hebrew Mt.	Carried 5-9, 19 30
20 UNDERTAKER Jack Lewis, 1439	ADDRESS E Balto St

Cor.—10-10-29—A Co.—100 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56976

CERTIFICATE OF DEATH

E 56976

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., Ward) 24-33

2-FULL NAME Alfred H. Williams.

(a) RESIDENCE NO. 326 S. Darlington St. West Chester Pa. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of Mary Lee Williams.

6 DATE OF BIRTH (month, day, and year) May 4th, 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	29	0	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Jockey.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Marshallton, Pa.
(State or country)

PARENTS

10 NAME OF FATHER Charles P. Williams

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Sarah E. Harvey.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania.

14 Informant Sarah Williams (mother)
(Address) 326 S. Darlington St. West Chester Pa

15 Filed MAY 9 - 1930 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull and crushed about the body. Fell from and crushed about the body by a falling horse in a race.

Accidental Death (duration) ..yrs. ..mos. ..da.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..da.

18 Where was disease contracted if not at place of death? Pimlico Race Track. May 8, 1930

Did an operation precede death? Yes. Date of May 8, 1930

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otho E. Kennady, M. D.

5/9, 1930 (Address) 1019 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Warrenton Va

DATE OF BURIAL 5-9 1930

20 UNDERTAKER Bernard C Hahn

ADDRESS 1008 S Paca St

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56977

CERTIFICATE OF DEATH.

E 56977
1-PLACE OF DEATH

REGISTERED NO. 100

CITY OF BALTIMORE: (NO. Union Memorial ST. 21-29 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Greenaway

(a) RESIDENCE NO. 720 N. West ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 8, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	6	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) Balto,
(State or country) Md.

PARENTS
10 NAME OF FATHER Edward Greenaway
11 BIRTHPLACE OF FATHER (city or town) Balto,
(State or country) Md.
12 MAIDEN NAME OF MOTHER Ella Van Meter
13 BIRTHPLACE OF MOTHER (city or town) Balto,
(State or country) Md.

14 Informant Mrs. E. Greenaway
(Address) 720 N. West.

15 Filed MAY 9 - 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8-1930

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1930 to May 8, 1930,
that I last saw h[illegible] alive on May 8, 1930
and that death occurred, on the date stated above, at 11[illegible] P.m.
The CAUSE OF DEATH* was as follows: (Dagligue)

Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) W. F. Stafford M. D.
May 8, 1930 (Address) Union Memorial

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.
DATE OF BURIAL May 10 1930
20 UNDERTAKER Wm. J. Ackerlons
ADDRESS North Ave

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56978 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56978

45

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3068-33 St. (Ward) 17-49

2-FULL NAME Mary Elizabeth Krauss

(a) RESIDENCE NO. 306 E 33rd St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Wm P. Krauss

6 DATE OF BIRTH (month, day, and year) Dec 5-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Henry C. Eyrnbrodt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm. P. Krauss (Address) 306-E-33 St

15 Filed MAY 9 1930, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8/30

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to May 8, 1930, that I last saw h alive on May 7, 1930, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Toxemia (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex

(Signed) J. M. Lamperin, M. D.

, 19 (Address) 3409 Gallaway Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

UNDERTAKER M. Frederick Sons

DATE OF BURIAL May 10 1930

ADDRESS Mt Royal

ATION is very important See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

56979

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56979

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No.) 2812 Elliott St., (or Ward) 14

2-FULL NAME Adolph Johnke

(a) RESIDENCE NO. 2812 Elliott St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Helen Bohnke.

6 DATE OF BIRTH (month, day, and year) Nov 6-1861

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	69	6	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Franz Bohnke

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Christian Praeger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Helen Bohnke
(Address) 2812 Elliott St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Broken Compensation (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? History
What test confirmed diagnosis?

(Signed) W. C. Glades, M. D.
. 19 (Address) 3 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart's East	May 10 1930
20 UNDERTAKER Lilly & Zeiler Inc.	ADDRESS 1128 W Fay

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 56980

E 56980

100-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. 1-1 WARD)

2-FULL NAME Baby Girl Heineman

(a) RESIDENCE NO. 2914 Hudson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5-1-30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Heineman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Maryan Ibel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14
Informant Hospital Record
(Address)

15
Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-8-30

17
I HEREBY CERTIFY, That I attended deceased from
5-1, 1930, to 5-8, 1930,
that I last saw h[illegible] alive on 5-8, 1930,
and that death occurred, on the date stated above, at 6[illegible] P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
bilateral

(duration) ....yrs. ....mos 3 da.

CONTRIBUTORY (Secondary) None

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death? Balt. City Hosp.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Lumpkin, M. D.

5-9, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	May 9 1930
20 UNDERTAKER Lilly & Geiler	ADDRESS 1630 W. North Ave

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56981

CERTIFICATE OF DEATH

32 ✓ E 56981

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (ST.) (14-30) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice De Minds

(a) RESIDENCE NO. 2021 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Walter H. De Minds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Helen Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Walter H De Minds

(Address) 2021 Madison Ave

15 Filed May 9 1930 C. HUGHSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to May 8, 1930, that I last saw h.er alive on May 8, 1930 and that death occurred, on the date stated above, at 7 15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningetis (Tuberculous)

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Spinal Puncture

(Signed) Myron G. Zell, M. D.

5/9/1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL 5/9/1930

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1631 Druid Hill Ave

IMPORTANT. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 56982

HEALTH DEPARTMENT—CITY OF BALTIMORE

E-56982

CERTIFICATE OF DEATH E 56982

188-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3613 Towanda St., 15-58 Ward)

2-FULL NAME Isaac Herschowitz

(a) RESIDENCE NO. 3813 Towanda St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena

6 DATE OF BIRTH (month, day and year) 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Henry Herschowitz

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Lena Herschowitz
(Address) 3813 Towanda

15 Filed ..., 19.. Registrar

MAY 9 - 1930 Filed

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Embolism Sudden

Probably due to stroke

ONTRIBUTORY (Secondary) Car accident Mar 25-1930 (duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death? Park Heights Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. B. Young, M. D.

May 8th 30 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairview Herring Run

DATE OF BURIAL 5-9-1930

20 UNDERTAKER Jack Levin, 1439

ADDRESS Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

E 56983

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56983

CERTIFICATE OF DEATH

188-103

1-PLACE OF DEATH

City of Baltimore: (No. South Balto Gen Hosp St., Ward)

2-FULL NAME Sutton Fowler

(a) RESIDENCE NO. 1434 Riverside St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Thomas

6 DATE OF BIRTH (month, day, and year) Oct 2-1865

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	64	7	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Ship Yds
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Sutton Fowler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Hazel Reed
(Address)

15 Filed MAY 9 1930 CLAUDSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto in which he was riding overturned Crushing him.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic Asphyxia

Following Crushed Chest (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Chesapeake Av Fairfield

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) G. J. Fraunce M. D.

5/9 1930 (Address) 2939 W. Eldeny

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friends Burial Ground Co Md	May 11 1930
20 UNDERTAKER Charles R. Stevens	ADDRESS 5 [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56984 ×45 ✓

CERTIFICATE OF DEATH

E 56984

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 E. 36th ST., 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Pekin Ill

2—FULL NAME Charles B. Grover

(a) RESIDENCE NO. 910 E 36th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~1~~ 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie M. Grover

6 DATE OF BIRTH (month, day, and year) Nov 5, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59.	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 31

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Thomas Grover

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Amanda Barnish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant D. C. Cleary Jr

(Address) 910 E 36th Street

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1930

17 I HEREBY CERTIFY, That I attended deceased from October, 1929, to May, 1930, that I last saw him alive on May 9, 1930 and that death occurred, on the date stated above, at 9 35 A m. Standard time

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

with metastasis

(duration) 2+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct 1929

Was there an autopsy? No

What test confirmed diagnosis? Pathological report

(Signed) Frederick D. Mark, M. D.

, 19 (Address) 827 N Charles ST

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pekin Illinois	May 13. 30
20 UNDERTAKER Wm Cook	ADDRESS 121 Fulton Ave

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 56985

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56985

CERTIFICATE OF DEATH

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2827 Reese St., 9-46 Ward)

2-FULL NAME Samuel Robinson

(a) RESIDENCE NO. 2827 Reese St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	Black	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Police Dept
(Address) UNIVERSITY OF MARYLAND

15 Filed ..., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Apr 21/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Insufficiency

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John Kain, M. D.

5/8/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL MAY 9 - 1930

20 UNDERTAKER

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 8 1930

40.39 - MORGUE

Spec.—1-12 23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56986 CERTIFICATE OF DEATH. 161-001 E 56986

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto. Genl Hosp ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby boy Stefanski.

(a) RESIDENCE NO. West Balto Genl Hosp ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-6-30

7 AGE Years Months Days If LESS than 1 day, 5 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work O.D.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Josyph Stefanski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Loretta Mc Dermott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) JOHNS

15 Filed 19 Registrar RMK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6- 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-6-30, 19, to 5-6-30, 19, that I last saw h alive on 5-6-30, 19, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) S-A Alesi M. D.

(Address) West Balto Genl Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL MAY 9 - 1930

20 UNDERTAKER Commissioner Health

ADDRESS

(See instructions on back of certificates. TION is very important.)

REG. NO. 16 HAROLD JONES, M. D.

Pop. Wm. S. Howell

Spec.—8-16-29—L. F. S.—100 Bks.

236388

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 56987

E 56987 CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 2-4 WARD)

2—FULL NAME Charles Martin

(a) RESIDENCE NO. 218 N. Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) S-Car-
(State or country)

PARENTS

10 NAME OF FATHER John Martin

11 BIRTHPLACE OF FATHER (city or town) S-Car-
(State or country)

12 MAIDEN NAME OF MOTHER Rose Jackson

13 BIRTHPLACE OF MOTHER (city or town) S-Car-
(State or country)

14 Informant Reads-

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 9 - 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2-30

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1930, to May 2, 1930, that I last saw him alive on May 2 1930, and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of nasopharynx with metastasis to glands of neck and filum of Lung

Syphilis (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Edward Stevenson, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL MAY 9 - 1930 19

20 UNDERTAKER

ADDRESS

Commissioner of Health

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

154-002 V

E 56988 CERTIFICATE OF DEATH

REGISTERED NO. E 56988

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST 24-32 WARD

2—FULL NAME Baby Holford

(a) RESIDENCE NO. 1319 Okeleston St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 24, 1930

7 AGE: Years | Months | Days: 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Kenzie Holford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Bernice Hay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: C. D. Douglas

(Address): Johns Hopkins Hospital

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-24, 1930, to 4-28, 1930

that I last saw her alive on 4-28, 1930

And that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. D. Douglas, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: MAY 9 - 1930

20 UNDERTAKER: Commissioner Health

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 56989

CERTIFICATE OF DEATH

E 56989

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No. 16-2 ST.) WARD)

2—FULL NAME Baby D'Amario

(a) RESIDENCE NO. 4326 E. Lombard ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 22 1930

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Andrew D'Amario

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rose S. Posluszny

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: C. Douglas (Address): JOHNS HOPKINS HOSPITAL

15 Filed 19 Registrar

4633

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-22 1930 to 4-22 1930

that I last saw him alive on 4-22 1930

and that death occurred on the date stated above, at 4.00 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Douglas M. D.

. 19 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: MAY 9 - 1930 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

IMPORTANT: See INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56990

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56990

CERTIFICATE OF DEATH

REGISTERED NO. 9

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 26-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Inez Young

(a) RESIDENCE NO. 523 N. East ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 11 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Girl	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER H. Underhill Young

11 BIRTHPLACE OF FATHER (city or town) N.Y.
(State or country)

12 MAIDEN NAME OF MOTHER Eliz Hopkins

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records

(Address) [illegible]

15 Filed G. HAMPSON JONES, M. D.
5-9-1930 By APH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8-1930

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to May 8, 1930, that I last saw her alive on May 8, 1930 and that death occurred, on the date stated above, at 1020 p.m.

The CAUSE OF DEATH* was as follows:

Pertussis pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cerebral haemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Phys exam

(Signed) [illegible], M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL MAY 10, 1930

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56991

E 56991

CERTIFICATE OF DEATH

129

REGISTERED NO. 15-67

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3033 Walbrook Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cornelia B. Roberts

(a) RESIDENCE NO. 3033 Walbrook Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Rev. William F. Roberts

6 DATE OF BIRTH (month, day, and year) June 22, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 27

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Rev. W. J. Floyd

11 BIRTHPLACE OF FATHER (city or town) Centreville

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliz. A. McCleary

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Rev. W. F. Roberts

(Address) 3033 Walbrook Ave.

15 Filed MAY 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 11th, 1930, to May 8th, 1930, that I last saw her alive on May 8th, 1930, and that death occurred, on the date stated above, at 2.05 P m.

The CAUSE OF DEATH* was as follows:

Senility

Cardio-Vascular

Renal disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. O'Byrne, M. D.

, 19 (Address) 3048 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL May 10 1930

20 UNDERTAKER Joseph Cook

ADDRESS 1003 West Baltimore St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56992 ✓ 46 E 56992

CERTIFICATE OF DEATH

REGISTERED NO. 27-53

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 Hawthorn Road. ST.) (WARD)

2—FULL NAME Anna Agatha Grogan.

(a) RESIDENCE NO. 208 Hawthorn Road. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Grogan.

6 DATE OF BIRTH (month, day, and year) Oct 4, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Prince George Co. Md.

PARENTS

10 NAME OF FATHER George Cranford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince Geo. Co.

12 MAIDEN NAME OF MOTHER Ella Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince Geo Co.

14 Informant Thomas J. Grogan

(Address) 208 Hawthorn Road.

15 Filed MAY 9 1930, 19 RKB Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1930, to May 8, 1930

that I last saw her alive on May 8, 1930

and that death occurred, on the date stated above, at 5 [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

36 hours —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma - Ovarian. 2-3 mos +.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of Mar. 6. 1930

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Carroll Stoddard, M. D.

May 9 1930 (Address) 4 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 5/11/30 19

20 UNDERTAKER C. Vernon Lemmon.

ADDRESS 7611 Park Heights Ave

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

382 Forest St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56993

E 56993

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 382 Forest St., 43-57 Ward)

2-FULL NAME Walter L Cooper

(a) RESIDENCE NO. 3607 Ash St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W Girl

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Blanche Cooper

6 DATE OF BIRTH (month, day, and year): May 1879

7 AGE: Years 51 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Oil
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Blanche Cooper
(Address) 3607 Ash St

15 Filed ....., 19.... RPM Registrar

MY 9 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) C. T. Peters, M. D.

May 9. 1930 (Address) 1659 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Industrial

DATE OF BURIAL: 5/10/1930

20 UNDERTAKER: J Walter Davis

ADDRESS: 330 Paine St

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write very plainly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56994

CERTIFICATE OF DEATH

74-001 V

E 56994

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2632 E Hoffman St. 8-16 Ward)

2-FULL NAME Katherine B. Goodwin

(a) RESIDENCE NO. 2632 E Hoffman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Walter B. Goodwin

6 DATE OF BIRTH (month, day, and year) Aug 25/1886

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	43	8	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Clinton O. Dorsey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Reistertown, Md.

12 MAIDEN NAME OF MOTHER Bell E. Shipley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Reistertown, Md

14 Informant Walter B. Goodwin
(Address) 2632 E. Hoffman St

15 Filed 5-9-1930 C. HARRISON JONES M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

5/9/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 9 1930
20 UNDERTAKER	ADDRESS
George L. Schwartz	210 Park Ave

IT SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHRASES indicating very OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56995 E 56995

CERTIFICATE OF DEATH

56995

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 704 Washington St., 16-66 Ward

2-FULL NAME Joseph Smith

(a) RESIDENCE NO. 704 Washington St., Ward

(If non-resident give city or town and State)

(Usual place of abode) 56

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Smith.

6 DATE OF BIRTH (month, day and year) Oct 10 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	70	6	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER [illegible] Smith

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs Mary E Smith
(Address) 704 W Washington St

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Senility

(duration) ....yrs. ....mos.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. Schmidt M. D.
Coroner.

May 8 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetary — DATE OF BURIAL May 10 1930

20 UNDERTAKER George L. Schwartz — ADDRESS 2101 Eutaw Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56996

CERTIFICATE OF DEATH

171 E 56996

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1836 Penna St. W (Ward)

2-FULL NAME Andrew E Jacobs.

(a) RESIDENCE NO. 1836 Penna Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years 59 | Months — | Days — | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Auto Repairer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md.

PARENTS

10 NAME OF FATHER:

11 BIRTHPLACE OF FATHER (city or town):
(State or country):

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town):
(State or country):

14 Informant: Andrew W. Jacobs
(Address): 1818 Harrington

15 Filed ..... 19..... C. HALPSON JONES Registrar
MAY 9 1930
Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide
Lacerated Throat
(Pocket Knife) Sudden
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Inquest Autopsy

(Signed) ..... M. D.

May 9 19 30 (Address) Coroner

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: May 10 1930

20 UNDERTAKER: Bernard A Feick — ADDRESS: 734 Poplar Grove St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56997

E 56997

CERTIFICATE OF DEATH

+ 118-001 ✓

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernest W. Vandermast

(a) RESIDENCE NO. Eastern Ave. & North Point Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma C. Vandermast

6 DATE OF BIRTH (month, day, and year) July 25. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adolph P. Vandermast

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Antonia Koke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Emma C. Vandermast (wife)

(Address) Eastern Ave & North Point Road

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to May 7, 1930

that I last saw h.i.m alive on May 7, 1930

and that death occurred, on the date stated above, at 8 37 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis & Cholangitis

Ventral Hernia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (secondary) Paralytic Ileus & Anemia

Pitrillatwo (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 29, '30.

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas. B. McClane M.D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL May. 11. 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore St & Broadway

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56998

CERTIFICATE OF DEATH.

129 E 56998

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital WARD 12-48

2-FULL NAME Raymond Sheppard

(a) RESIDENCE NO. 210 St. Dunstans Road WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? 49 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Violet Sheppard

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mfg. Agent

(b) General nature of Industry, business, or establishment in which employed (or employer) Shirt

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER John Sheppard

11 BIRTHPLACE OF FATHER (city or town) Salem (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Rubena Garrison

13 BIRTHPLACE OF MOTHER (city or town) Salem (State or country) New Jersey

14 Informant John B. Sheppard (son)

(Address) 210 St Dunstans Rd

15 9 - 1930 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8/30. 19

17 I HEREBY CERTIFY, That I attended deceased from 5-7, 1930. to 5-8. 1930.

that I last saw him alive on 5-8, 1930.

and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows: Chronic nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) George Burns, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL May 10 1930

20 UNDERTAKER Stewart & Mowen Company ADDRESS Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 56999 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56999

CERTIFICATE OF DEATH.

REGISTERED NO. 10109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hospital St. 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME AMELIA J. Mrs. John T. Davis

(a) RESIDENCE NO. 3102 Fremont Ave ST.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred L yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND (or) WIFE of John T. Davis

6 DATE OF BIRTH (month, day, and year) July 25, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Jacob Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland Frederick

12 MAIDEN NAME OF MOTHER Anna Hoop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Hugh D. Clipper (Address) 3102 Fremont Ave

15 Filed ....., 19 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9-1930

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to May 9, 1930, that I last saw h Lr alive on May 9, 1930, and that death occurred, on the date stated above, at 11: A m.

The CAUSE OF DEATH* was as follows:

Tubus pulmonum.

(duration) ....yrs. ....mos 9 ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray + Clinically.

(Signed) Nicholas Lamparad, M. D.

, 19 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: May 12th 1930

20 UNDERTAKER: Bertram Dyde — ADDRESS: 1723 W Lafayette Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 57000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 57000

1—PLACE OF DEATH Franklin Square Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... St.) (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James T. Hall

(a) RESIDENCE NO. 3012 Windsor Ave ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Hall

6 DATE OF BIRTH (month, day, and year) Nov 14th 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Coffee & Tea

(c) Name of employer L. P. Kemp's Sons

9 BIRTHPLACE (city or town) Thurmont Md
(State or country)

PARENTS

10 NAME OF FATHER John Hall

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Emma Hall

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Emma Hall
(Address) 3012 Windsor Ave

15 Filed 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8/30

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1930, to May 8th, 1930, that I last saw h.. alive on May 8th, 1930, and that death occurred, on the date stated above, at 7½ P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) terminal bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs & laboratory

(Signed) L. Pattenini, M. D.

19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 10th 1930
20 UNDERTAKER	ADDRESS
Peters and Lee	1723 W. Fayette St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57001 101-001 E 57001

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital STREET (or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Elizabeth (Lizzie) Lynn

(a) RESIDENCE NO. St. Martin's Rectory WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 1883

7 AGE: Years 46 | Months 11 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 610

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Wm Lynn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elly Keenan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Jenny Lynn

(Address) 30 W Fulton Ave

15 Filed MAY 6 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/9/30

17 I HEREBY CERTIFY, That I attended deceased from 5/5, 1930, to 5/9, 1930, that I last saw h alive on 5/8, 1930 and that death occurred, on the date stated above, at 2:35 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ludwigs

(Signed) Theo. E Stacy, Jr., M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	5/12/30
20 UNDERTAKER: Engel & Staby	ADDRESS: Fulton & Fayette

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57002

CERTIFICATE OF DEATH

129 E 57002

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5809 Bellona ST. 22-48 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. McCormick

(a) RESIDENCE NO. 5809 Bellona ST. 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel McCormick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Harriet Dalton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Eliz. Hutchins

(Address) 5809 Bellona Ave

15 Filed 9 1930, 19 Ret. Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to May 7, 1930, that I last saw h alive on May 7, 1930 and that death occurred, on the date stated above, at 3.3 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Chr. Myocarditis, Chr. G.U. Nephritis

(duration) 5+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac decompensation (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S. L. Bishop, M. D.

May 8, 1930 (Address) 501 Sheldon Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 5/10/30

20 UNDERTAKER Geo. A. Tetley Sons

ADDRESS Fayette

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57003

CERTIFICATE OF DEATH

31 ✓

E 57003

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1933 W Fayette St. WARD) 20-27

2—FULL NAME Charles H Wenzing

(a) RESIDENCE NO. 1933 W Fayette St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of: Augusta Wenzing

6 DATE OF BIRTH (month, day, and year): Apr 26 1863

7 AGE: Years 55 | Months | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Furniture Mfr

(b) General nature of industry, business, or establishment in which employed (or employer): Salesman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Otto Wenzing

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Ostermann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary A Wenzing

(Address): 1933 W Fayette St

15 Filed 9 1930, 19 Pat 1911 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-8-30

17 I HEREBY CERTIFY, That I attended deceased from July 30 19 13 to May 7 19 30

that I last saw h alive on May 7 19 30

and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

Contributory Cardiac Asthenia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) 1933 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catholic Cem

DATE OF BURIAL: 5/10/30

UNDERTAKER: Engel & Sons

ADDRESS: Fulton & Fayette

Spec.—1-30—M. & T.—250 Blks

Dr. Rackard
3201 St Paul St ✓

E 57004 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 57004

114.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3201 St Paul St. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carolina Norris

(a) RESIDENCE NO. 3201 St Paul ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Norris

6 DATE OF BIRTH (month, day, and year) Apr 6th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 37

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Wirth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs H. L. Rackard (Address) 3201 St Paul St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH 3:30 a.m.

16 DATE OF DEATH (month, day, and year) May 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1930, to May 8th, 1930, that I last saw her alive on May 8, 1930 and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

a Chronic Intes-Colitis

(duration) — yrs. 3 mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination of Stools

(Signed) H. L. Rackard, M. D.

5/9, 1930 (Address) 3201 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL 5/10/1930

20 UNDERTAKER Wm Cook 1207 St Paul St — ADDRESS

MAY 9 1930

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57005

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57005

CERTIFICATE OF DEATH

REGISTERED NO. 13-57

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)
CITY OF BALTIMORE: (No. Children's Hospital School ST. WARD)

2—FULL NAME Dorothy Harry Mann

(a) RESIDENCE NO. North Linthicum Heights, Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	1	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School.
(b) General nature of industry, business, or establishment in which employed (or employer) Hospital School
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Linthicum Hgts Md.

PARENTS

10 NAME OF FATHER William H. Harry Mann.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.
12 MAIDEN NAME OF MOTHER Annie Jacobs.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Antwerp Belgium

14 Informant Wm. H. Harry Mann
(Address) North Linthicum Hgts Md

15 Filed MAY 9 1930 C. HAMPSON JONES, M. D. Registrar
By RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7-1930.

17 I HEREBY CERTIFY, That I attended deceased from 1-17-1930, to 5-7-1930,
that I last saw h alive on 5-7-1930,
and that death occurred, on the date stated above, at 4 P.M. m.

The CAUSE OF DEATH* was as follows:
Post Operative Shock - Complicating Osteo Myelitis 1 hour

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Osteo Myelitis Rt Femur.
(duration) 1 yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? At Home
Did an operation precede death? Yes Date of 5-7-30.
Was there an autopsy? None
What test confirmed diagnosis? Wound Syphilis - Operations.
(Signed) Raymond E. Leonard, M. D.
19 (Address) Children's Hosp. School

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 5/10/1930

UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

See instructions on back of certificates. Important.

Spec.—1-30—M. & T.—250 Blks

D. Emmor
c.o

Park Heights Ave
Garrison Liberty 1515

E 57006 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57006

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4920 Palmer Ave ST. 27-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M. Small

(a) RESIDENCE NO. 4920 Palmer Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Louis Small

6 DATE OF BIRTH (month, day, and year) Aug 5th 1862

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) Troy
(State or country) N. Y.

PARENTS

10 NAME OF FATHER Frederick Knies

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. Y.

12 MAIDEN NAME OF MOTHER Mary Ryan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. Y.

14 Informant Margaret M. Lipsen
(Address) 4920 Palmer Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930 to May 9, 1930, that I last saw ~~him~~ her alive on May 9, 1930, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Few Hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & clinical findings

(Signed) E. D. Emmor, M. D.

5-9, 1930 (Address) 4936 Portland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 5/12/1930

20 UNDERTAKER Wm Cook

ADDRESS 1207 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 57007

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 129

E 57007

1—PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1807 McCulloh ST. 14-20 WARD)

2—FULL NAME Harris Lee

(a) RESIDENCE NO. 1807 McCulloh ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 0 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 8-1865

7 AGE: Years 65 | Months 3 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 86

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Chas. Co. Md

PARENTS

10 NAME OF FATHER: John Lee

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliza Anderson

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Md

14 Informant: Mamie Rosser (Address): 1807 McCulloh St

15 Filed ..... 19 ..... Registrar

MAY 9 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8/30

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to May 8, 1930, that I last saw h[illegible] alive on May 8, 1930 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Degeneration & Arteriosclerosis

(duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E. N. Hatcher, M. D.

5/8, 1930 (Address) 1 W Fayette St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pt Lookout Md — DATE OF BURIAL: May 10 1930

20 UNDERTAKER: Samuel T. Hemsley — ADDRESS: W Biddle

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57008 E 57008

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hosp ST., 9 18 WARD)

2-FULL NAME Catherine Madigan

(a) RESIDENCE NO. 731 E. Hoffman ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ... ds. How long in U. S., if of foreign birth? 70 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Madigan

6 DATE OF BIRTH (month, day, and year) 12/11/1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Daniel Michael Madigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Miss O'Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Fred. Dill

(Address) 1920 Eastern Avenue.

15 Filed ..... 19 ..... Registrar

MAY 9 1930 C. HARRISON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-13 1930 to 5-8 1930 that I last saw h alive on 5-8 1930 and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Gangrene
Gall Bladder disease
(duration) yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) Toxaemia -
(duration) yrs. ... mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W B Kinney M. D.

(Address) 1st Wash Hyde

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL 5/11/30

20 UNDERTAKER Mary T. Ruth ADDRESS 735 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

(Terjung)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57009 E 57009

CERTIFICATE OF DEATH.

129

REGISTERED NO. 9-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2219 Kirk Ave ST., WARD)

2-FULL NAME Felix H. Terjung

(a) RESIDENCE NO. 2219 Kirk Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Terjung

6 DATE OF BIRTH (month, day, and year) 12-26-1877

7 AGE Years	Months	Days	If LESS than 1 day ...hrs. or ...min.
53	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Terjung

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Annie Terjung

(Address) 2219 Kirk Ave

Filed 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1st, 1930, to May 7th, 1930.

that I last saw h[illegible] alive on May 7th, 1930

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. E. Maynard M. D.

5/9, 1930 (Address) 14 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 5/10/30

20 UNDERTAKER Mary T. Puth

ADDRESS 1035 Hanover

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57010

CERTIFICATE OF DEATH

5 E 57010

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2521 E. Oliver ST. 8-16 WARD)

2—FULL NAME Robert C. Pilsch

(a) RESIDENCE NO. 2521 E. Oliver ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 12 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	4	25 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~none~~

(b) General nature of industry, business, or establishment in which employed (or employer) School Boy

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jacob Pilsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Fannie C. Colvin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C.

14 Informant Jacob Pilsch
(Address) 2521 E. Oliver St.

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1930, to May 8, 1930, that I last saw him alive on May 8, 1930 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia Paralysis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. 1 mos. 8 ds.

18 Where was disease contracted if not at place of death? ~~none~~

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) H. C. Hoffman, M. D.

May 9, 1930 (Address) 301 N Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: May 10 1930

20 UNDERTAKER: John C. Miller — ADDRESS: 2435 E Oliver St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57011

CERTIFICATE OF DEATH

E 57011

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2945 Fait Ave ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Zelkowski

(a) RESIDENCE NO. 616 S. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Zelkowska

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Labor NC

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Zelkowska

(Address) 616 S. Washington St.

15 Filed 9 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1930

17 I HEREBY CERTIFY, That I attended deceased from May 4- 1930, to May 7- 1930, that I last saw h. in alive on May 6- 1930 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) chr. Bronchitis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. J. Davidow, M. D.

, 19 (Address) 3035 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery

DATE OF BURIAL May 10 1930

20 UNDERTAKER John M Weber

ADDRESS 401 Chester Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 57012

E 57012

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4507 Hamilton Ave St. 27-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia A. Diffenderfer

(a) RESIDENCE. NO. 4507 Hamilton Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Diffenderfer

6 DATE OF BIRTH (month, day, and year) Nov. 8-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER James A. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Lydia Pipe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs William Hutchinson (Address) 4507 Hamilton Ave

15 Filed MAY 10 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 3rd, 1930, to May 9th, 1930, that I last saw h[er] alive on May 9th, 1930, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Benedict

(Signed) Robert L. Cantwell, M. D.

5/10, 1930 (Address) 711 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cumberland May 10 30

20 UNDERTAKER ADDRESS

A S Marshall 1539 Hall St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 57013 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57013

129

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 165 Mullikin St. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Samuel Hollis

(a) RESIDENCE NO. 165 Mullikin ST., WARD.

(Usual place of abode) (If non-resident give City or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hollis

6 DATE OF BIRTH (month, day, and year) [illegible] 1862

7 AGE Years 68 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Hollis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annie Branch

(Address) 1615 Mullikin St

15 Filed MAY 10 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1930

17 I HEREBY CERTIFY, That I attended deceased from 1929, 19—, to March 18, 1930, that I last saw him alive on March 18, 1930, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 607 S. Chapel St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) H. S. Cornish, M. D.

May 7, 1930 (Address) 129 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine cemetery

DATE OF BURIAL May 10 1930

20 UNDERTAKER John H. Foderer

ADDRESS 1127 Druid Hill Ave

MAY 10 1930

Handwriting in ink is necessary. Applicant must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57014

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57014

CERTIFICATE OF DEATH

Ped

1—PLACE OF DEATH

REGISTERED NO. 113

CITY OF BALTIMORE: (No. ~~JOHNS HOPKINS HOSPITAL~~ ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leroy L Gray

(a) RESIDENCE NO. 55 Ridgewood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1/22/30

7 AGE	Years	Months 3	Days 16	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Robert Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ella Gregg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 0 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-8-30

17 I HEREBY CERTIFY, That I attended deceased from 4-29, 1930, to 5-8, 1930, that I last saw him alive on 5-8, 1930 and that death occurred, on the date stated above, at 3:42 P m.

The CAUSE OF DEATH* was as follows:

Acute entero-colitis, non-specific.

Otitis Media

(duration) yrs. mos. 12 ds.

CONTRIBUTORY [redacted] Pneumonia, terminal

(Secondary)

Thrombosis Lat. Sinus (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) mary adams, M. D.

5/9, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL May 10 1930

20 UNDERTAKER Mrs. R. C. Elliott

ADDRESS 1725 Eastlander

Spec.—1-10-21—M&T—1500 Bks.

E 57015

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 V E 57015

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N. Fremont Av ST. 16-23 WARD

2-FULL NAME John Henry Addison

(a) RESIDENCE NO. 808 N. Fremont Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellenora Addison

6 DATE OF BIRTH (month, day, and year) [illegible] 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor 0/6

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Ellenora Addison
(Address) 808 N. Fremont Ave

15 Filed ..... 19 ..... Registrar

ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 7, 1930, that I last saw him alive on May 7, 1930, and that death occurred, on the date stated above, at 4.05 P. m. (Standard)

The CAUSE OF DEATH* was as follows: Diabetes Mellitus + Chr Parenchymatous Nephritis

(duration) 1 (?) yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinic

(Signed) H H Hughes, M. D.

5/8, 1930 (Address) 825 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL May 10, 1930

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57016

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

E 57016

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 945 W Lombard ST. 16-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James A. Jacobs.

(a) RESIDENCE NO. 945 W Lombard ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 25th 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James A. Jacobs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Clara Wyatt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Mrs. James A. Jacobs

(Address) 945 W Lombard St.

15 C. HAMPSON JONES, M. D. Registrar

0 T930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1930, to May 9, 1930, that I last saw him alive on May 9th 1930. and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myo-Carditis

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Blue Baby

(duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam Etc.

(Signed) J. Thurston, M. D.

5/9. 1930 (Address) 888 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 5/10/1930

20 UNDERTAKER John F. Cowan & Son.

ADDRESS 901 Hollins St.

Important: See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57017

CERTIFICATE OF DEATH

90 ✓ E 57017

1—PLACE OF DEATH

REGISTERED NO. 13-20

CITY OF BALTIMORE: (No. 714 E. North Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J. McWhirter

(a) RESIDENCE NO. 714 E. North Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 10 mos. 25 ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Lynch

6 DATE OF BIRTH (month, day, and year) June 13, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Archibald McWhirter

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mathilda Hughes

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Elizabeth L. McWhirter

(Address) 9 E. Chase Street

15 Filed 1 0 1930 C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from ....., 1926, to May 8, 1930, that I last saw him alive on May 8, 1930 and that death occurred, on the date stated above, at 10.30 m.

The CAUSE OF DEATH* was as follows:

Chd Myocarditis

Angina Pectoris

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Artery Occlusion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Chas. W. Cousins M.D., M. D.

5/10, 1930 (Address) 9 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 5/10 1930

20 UNDERTAKER Henry U. Mears and Son

ADDRESS 805 N. Calvert

IMPORTANT: See instructions on back of certificate.

James Stec

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57018 ✓ E 57018

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital S. 2-4 WARD)

2-FULL NAME James Stock (Stec)

(a) RESIDENCE NO. 128 S. Castle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 17-22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michal Stec

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine Rinta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mother
(Address) 128 S Castle

15 Filed ..... 19..... By..... Registrar

C. HAMPSON JONES, M. D.

1 01 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-8 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-3-30, 19..., to 5-8, 1930.

that I last saw him alive on 5 8 30, 19...,

and that death occurred, on the date stated above, at 10,45 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. ..... mos 20 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Physical findings.

(Signed) M Buckley, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus

DATE OF BURIAL May 12 1930

20 UNDERTAKER F W Ozozewski 1930

ADDRESS Eastern a.

CAUSE OF DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57019

CERTIFICATE OF DEATH

74001

E 57019

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 405 W Pratt ST. 12-30 (WARD)

2—FULL NAME Emma. Hauer

(a) RESIDENCE NO. 405 W. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word)
Female	White.	Widow.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Franklin W. Hauer

6 DATE OF BIRTH (month, day, and year) Feb. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER M. Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER M. Schmoneck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Henry J. Hauer

(Address) 405 W. Pratt st.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-8-30

17 I HEREBY CERTIFY, That I attended deceased from 5-5-30, 1930, to 5-8, 1930, that I last saw h[illegible] alive on 5-8, 1930 and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) Walter A. [illegible], M. D.

5/10, 1930 (Address) 541 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 12th 30
20 UNDERTAKER	ADDRESS
Fred A. Wanderson	703 Hanover

10 1930

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57020

E 57020

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 N. Wolfe ST. 713 WARD)

2-FULL NAME Tamer Bennett

(a) RESIDENCE NO. 804 N. Wolfe. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) march 4. 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
52	51	8	3	

8 OCCUPATION OF DECEASED House Wife

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N C

PARENTS

10 NAME OF FATHER Jabe McCormick

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Tamer Wolford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Richard Bennett (Address) 804 wolf st

15 Filed 10 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-7- 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-28-, 1930, to 5-7-, 1930, that I last saw h[illegible] alive on 5-5-, 1930 and that death occurred, on the date stated above, at 7,50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Salpingitis.

(duration) unknown. yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) 611 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wadesboro N C — DATE OF BURIAL may 10 1930

20 UNDERTAKER Edward Bryan — ADDRESS 1631 orleans st

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57021 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57021

CERTIFICATE OF DEATH.

32

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST. 2-4 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Roth

(a) RESIDENCE NO. 1735 Lancaster ST., 2 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Roth

6 DATE OF BIRTH (month, day, and year) 5-22-83

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46 11 17	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Roth

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Records of (Address) Balto. City Hosp.

15 Filed ....., 19 ..... Registrar

10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-9-30

17 I HEREBY CERTIFY, That I attended deceased from 4-30-30, 19..., to 5-9-30, 19..., that I last saw h... im alive on 5-9-30, 19..., and that death occurred, on the date stated above, at 12:40 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Meninges (Tuberculous meningitis)

(duration) ... yrs. 1 mos ... da.

CONTRIBUTORY (Secondary) Nephritis, chronic, without oedema (duration) 4 yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? clinical, lab.

(Signed) Paul Padget, M. D.

5-9, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cemetery	May 13/30

20 UNDERTAKER Lilly & Zeiler Inc. ADDRESS 403 S. Wolfe St.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57022

E 57022

CERTIFICATE OF DEATH

REGISTERED NO. 11-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 21. N. Caroline ST. 6-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sallie Gibson

(a) RESIDENCE NO. 21. N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Phil Gibson

6 DATE OF BIRTH (month, day, and year) April 7 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of indostry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer not known

9 BIRTHPLACE (city or town) Easton (State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) not Known (State or country) Not Known

12 MAIDEN NAME OF MOTHER Julie Pickham

13 BIRTHPLACE OF MOTHER (city or town) Queen Anne Co (State or country) Md

14 Informant Clarence Gibson

(Address) 21 N. Caddmer st.

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to May 8, 1930, that I last saw h.. alive on May 7, 1930 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(doration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ....yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Richard L Eastwijfer, M. D.

, 19 (Address) 514 S Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injory, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md — DATE OF BURIAL May 10 1930

20 UNDERTAKER Eduard Bryan — ADDRESS 1631 orleans st

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57023

101-001

E 57023

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 14 N Mount St. 19-27 Ward)

2-FULL NAME James W Scott

(a) RESIDENCE NO. 14 N Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) May 15, 1897

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	33	1	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Jas H Scott

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Carrie Simon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Carrie Scott
(Address) 14 N. Mount

15 Filed ... 19... HARRISON JONES M.D. Registrar

MAY 10 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas G Brooke, M. D.

5/9, 1930 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
National Cemetery

DATE OF BURIAL
May 12, 1930

20 UNDERTAKER
Mrs Katie R Williams

ADDRESS 3221 Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 57024

E 57024

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 N Carrollton Ave 6-23 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph F. Bingham Jr.

(a) RESIDENCE NO. 710 N Carrollton Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Columbia S.C.

PARENTS

10 NAME OF FATHER Joseph Bingham

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Mary J. Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Mrs. B. Spencer (sister)

(Address) 710 N Carrollton Ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1930

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to May 8, 1930, that I last saw him alive on May 7, 1930 and that death occurred, on the date stated above, at 4.35 A.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency and (Adhesive) pericarditis (according to history)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R Lipsman M. D.

5/8, 1930 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL May 10, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 3221 Schroeder St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 ✓

E 57025

REGISTERED NO. E 57025

E 57025

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1314 N Broadway St. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles M Budd

(a) RESIDENCE NO. 1314 N Broadway St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: W

4 COLOR OR RACE: W

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of ~~(or) WIFE of~~: Margaret J. Budd

6 DATE OF BIRTH (month, day, and year): Jan. 2, 1870

7 AGE: Years 60; Months 5 4; Days 6; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Charles County Maryland

PARENTS

10 NAME OF FATHER: John L Budd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Carpenter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Margaret J Budd (Address) 1314 N Broadway

15 Filed MAY 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 1930

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1930, to May 8, 1930, that I last saw h in alive on May 8, 1930, and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arteriosclerosis (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fx. Hip on wife caused (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Clark Thomas, M. D.

(Address) 1228 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: May 12 1930

20 UNDERTAKER: Robt J Turner

ADDRESS 1442 N Broadway

Spec.—1-30—M. & T.—250 Bks.

E 57026 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57026

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH Mercy Hosp. Tal

CITY OF BALTIMORE: (No. 11-24 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salome Dameron

(a) RESIDENCE NO. 353 Carrel St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored Negro

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years 44 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Dylan Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mag Ringold

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Adlet Tucker

(Address): 535 Carrel St

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

1 0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 1930

17 I HEREBY CERTIFY, That I attended deceased from 5/6/30, 19..., to 5/8/30, 19...

that I last saw h[illegible] alive on 5/8/30, 19...

and that death occurred, on the date stated above, at 10 55 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Jenner, M. D.

5/8/30 19 (Address) Mercy Hosp. Tal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shanks Md

DATE OF BURIAL: 5-10 19 30

20 UNDERTAKER: Daniel Carter

ADDRESS 846 E a ve

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57027 (REGISTERED NO.) 101-001 57027 E 57027

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 742 Bradley ST. 17-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Sample

(a) RESIDENCE NO. 742 Bradley ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced: HUSBAND of (or) WIFE of Charles Sample

6 DATE OF BIRTH (month, day, and year): 1906

7 AGE: Years 24 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Phillis Kellum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Charles Sample (Address) 742 Bradley St

15 [illegible] C. HAMPSON JONES, M. D. Registrar

1930 Pct. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9 1930

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to May 9, 1930, that I last saw [illegible] alive on May 6, 1930 and that death occurred, on the date stated above, at 1130 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

, 19 (Address) 1532 Edgar

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenock Va

DATE OF BURIAL: 5-10-30

20 UNDERTAKER: Hans Evans

ADDRESS 716 Penn

Spec.—1-10-21—M&T—1500 Blks.

E 57028

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57028

CERTIFICATE OF DEATH.

X 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital 9-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Murray

(a) RESIDENCE NO. Turner's Station 2nd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) M

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Elbert Murray

6 DATE OF BIRTH (month, day, and year) Apr 15- 1890

7 AGE Years 40 Months Days 21 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Keysville Va

PARENTS

10 NAME OF FATHER Wm Taxdale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Diane Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Ellen Jackson

(Address) 929 N Wolf

15 Filed [illegible] 1930 . 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1930

17 I HEREBY CERTIFY, That I attended deceased from May 2 . 1930 . to May 6 . 1930 .

that I last saw her alive on May 6 . 1930 .

and that death occurred, on the date stated above, at 2 00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis c hypertension ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M B Wheatley, M. D.

5-6 1930 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem

DATE OF BURIAL May 9 1930

20 UNDERTAKER Sam'l H. Chase & Son

ADDRESS 1401 Maker

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57029 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57029

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals S. 11-2 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Julia Saunders Dorsey

(a) RESIDENCE NO. 1104 McCullough St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colordd	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Benj. Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sally Ann ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-3-30

17 I HEREBY CERTIFY, That I attended deceased from 11-3-27, 19..., to 5-3-30, 19..., that I last saw her alive on 5-3-30, 19..., and that death occurred, on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) 3 yrs. 6 mos ..... da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 4 da.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padget, M. D.

5-9-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL May 13, 30

20 UNDERTAKER Sam'l R. Chase & Son ADDRESS 1400 Mosher

Spec.—1-30—M. & T.—250 Bks.

E 57030

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 57030

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 E. 23rd. St. ST. 9-46 WARD)

2-FULL NAME Thaddeus M. Bell

(a) RESIDENCE NO. 521 E. 23rd. St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie E. Bell

6 DATE OF BIRTH (month, day, and year) Oct. 19th. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thaddeus Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary McCarriar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Fannie E. Bell (Address) 521 E. 23rd. St.

15 May 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8th. 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 28, 1930, to May 8, 1930, that I last saw h alive on May 8, 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocarditis and Cardiac Decompensation (duration) ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed) Chas. Krumbhaar, M. D.

(Address) 4 W. Hamilton

May 10 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Episcopal Cemetery

DATE OF BURIAL May 11 1930

ADDRESS

UNDERTAKER Chas. P. Graves & Son 1187 Mt Royal Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57031

CERTIFICATE OF DEATH.

10 E. 5703 1

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 423 Lanvale St. (E. or W.) (WARD) 11-20

2-FULL NAME Columbus Peek

(a) RESIDENCE. NO. 423 Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna. Lee. Peek

6 DATE OF BIRTH (month, day, and year): 1903

7 AGE: Years 27 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Balto. Copper Wks.

(c) Name of employer: Baltimore Copper Wks.

9 BIRTHPLACE (city or town) (State or country): Crawfordville Ga.

PARENTS

10 NAME OF FATHER: John. P. Peek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Crawfordville, Ga.

12 MAIDEN NAME OF MOTHER: Margaret Peek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Crawfordville, Ga.

14 Informant (Address): Wm. B. Caldwell 423 Lanvale St. City

15 Filed ....., 19..... Registrar

10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 8, 1930

that I last saw h. alive on May 7, 1930

and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Bright's Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tonsilitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry E. Wilson M.D.

5-9. 1930 (Address) 3 W. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount DATE OF BURIAL: May 11 1930

20 UNDERTAKER: Wm. H. Coffee & Son ADDRESS: 1400 Madison

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57032 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57032

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B. 10 ST., WARD)

CITY OF BALTIMORE: (NO. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Grund

(a) RESIDENCE NO. 2506 E. Fairmount ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sign painter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 1930 C. HALLESON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to May 8, 1930, that I last saw him alive on May 8, 1930, and that death occurred, on the date stated above, at 10.20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Glennon Jr, M. D.

5-8, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 5/12/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-10-21—M&T—1500 Bks.

E 57033 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57033

CERTIFICATE OF DEATH. 90

REGISTERED NO. .....

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St Joseph's Hosp. St. 1946 WARD)

2-FULL NAME Concetta Tamburo

(a) RESIDENCE NO. 715- E. 22nd ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced, (write the word)~~: Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Salvatore Tamburo

6 DATE OF BIRTH (month, day, and year): Aug 15th 1864

7 AGE: Years 65 Months 8 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Joseph Zito

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Philomena Conza

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Salvatore Tamburo 715 E 22nd St

15 Filed: 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-9 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-4, 1930, to 5-9, 1930, that I last saw h alive on 5-9, 1930 and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M B Hendrix, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: 5/12 1930

20 UNDERTAKER: Vorhaus Cook

ADDRESS: 1475 St Paul

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57034

CERTIFICATE OF DEATH

90 E 57034

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.)

No. 13 S. Robinson ST. 1-2 WARD)

2—FULL NAME Irene Ervin

(a) RESIDENCE NO. 13 S Robinson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

6a If married, widowed, or divorced (or) WIFE of Joseph H. Ervin

6 DATE OF BIRTH (month, day, and year) Jan 17-1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Alphonsus Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Agnes Rhode

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Mrs Jos Ervin St. (Address) 13 S. Robinson

15 Filed 1 0 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1930.

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1928, to May 7, 1930, that I last saw her alive on May 7, 1930, and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel Brooke M. D.

May 9, 1930 (Address) 1331 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL 5/10 1930

20 UNDERTAKER J. F. Doran

ADDRESS 3000 E. Balto

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57035

90 E 57035

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1707 Lakeside Ave. ST. (WARD) 13-59

2-FULL NAME Leonie deCaulne Head

(a) RESIDENCE NO. 1707 Lakeside Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Washington B. Head

6 DATE OF BIRTH (month, day, and year) Sept. 16, 1879.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harpers Ferry W. Va.

PARENTS

10 NAME OF FATHER John W. Doll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Washington B. Head

(Address) 1707 Lakeside Ave.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from December 3, 1929, to May 7, 1930, that I last saw h[illegible] alive on May 7, 1930, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Oliver C. Ohlweiler, M. D.

5/9, 1930 (Address) 2[illegible] E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park

DATE OF BURIAL 5/10/30

20 UNDERTAKER Harry A. Mitzke 4101

ADDRESS Edmondson Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57036

CERTIFICATE OF DEATH.

44 E 57036

REGISTERED NO.

1-PLACE OF DEATH Md General Hosp.

CITY OF BALTIMORE: (No. Howard & Madison ST. 20-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma Vincent

(a) RESIDENCE NO. 3409 W Franklin ST., WARD

(If non-resident give city or town and State)

(Usual place of abode) about

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Wm. Vincent

6 DATE OF BIRTH (month, day, and year) Mar 16, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N. W. 31

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Thomas Nickles

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Jane Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hosp Records (Address)

15 Filed 0 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1930

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1930, to May 9, 1930, that I last saw her alive on May 9, 1930, and that death occurred, on the date stated above, at 5-20 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Gall bladder + Liver

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of April 7, 1930

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H. W. Kretschmer, M. D.

5/9, 1930 (Address) Md General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camden S. Carolina — DATE OF BURIAL 5/10/30

20 UNDERTAKER Harry A Witzke — ADDRESS 401 Edmondson Ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

51037
57037

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57037

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 12-50 WARD)

2-FULL NAME Eugene Burns.

(a) RESIDENCE NO. 2221 Guilford Ave ST., ... WARD .....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 28 ds. How long in U. S., if of foreign birth? yrs. 6 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Robert Burns

11 BIRTHPLACE OF FATHER (city or town) Balt.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Bianca Taylor

13 BIRTHPLACE OF MOTHER (city or town) Balt.
(State or country) Md.

14 Informant Robert Burns
(Address) 2221 Guilford

15 Filed ....., 19 C. HARTMAN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 9, 1930, that I last saw him alive on May 8, 1930, and that death occurred, on the date stated above, at 3 45 A m. (daylight)

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ....yrs. ....mos 8 ds.

CONTRIBUTORY (Secondary) Pneumococcic Meningitis 18h

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? 2221 Guilford Ave

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture Pneumococcus

(Signed) H. G. Schaefer Jr. M. D.

May 9, 1930 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL May 12 1930.

20 UNDERTAKER Curley & Co. Inc.

ADDRESS 1021 Cypress Ave

Spec.—1-12-23—M&T—500 Blks.

E 57038 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57038

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3006 Poplar Ter WARD) 15-61

2-FULL NAME Henrietta Griffith Jones

(a) RESIDENCE NO. 3006 Poplar Ter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 7 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis T. Jones

6 DATE OF BIRTH (month, day, and year) Aug 26 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.,

PARENTS

10 NAME OF FATHER Reuben Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.,

12 MAIDEN NAME OF MOTHER Margaret J. Colston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.,

14 Informant Henrietta Jones Robertson

(Address) 3006 Poplar Ter

15 Filed MAY 10 1930 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 27, 1930, to May 10, 1930.

that I last saw h[illegible] alive on May 9, 1930

and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Peltz, M. D.

, 19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet

DATE OF BURIAL May 13 1930

20 UNDERTAKER Vernon Keehner

ADDRESS 163 Hollins

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57039

E 57039

CERTIFICATE OF DEATH

+ 101-09

REGISTERED NO. 4-30

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

2—FULL NAME Morris Williams

(a) RESIDENCE NO. Ellicott City Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	4	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Birtie Mulvin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed ....., 19 ..... Registrar

1 0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to May 10, 1930, that I last saw h.. alive on May 10, 1930, and that death occurred, on the date stated above, at 6:15 A.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Lewis A. Gundry, M. D.

5-10-1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL May 12, 1930

ADDRESS Ellicott City

20 UNDERTAKER Easton Sons

Spec.—1-12-23—M&T—500 Blks.

E 57040 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57040

CERTIFICATE OF DEATH.

REGISTERED NO. 118-04

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1035 Sharp St. (WARD) 23-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raphael Mercer

(a) RESIDENCE NO. Provident Hospital WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Mercer

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0 to 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William & Mercer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Mercer (Address) 1035 Sharp St

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-7-1930

17 I HEREBY CERTIFY, That I attended deceased from 5-3-, 1930, to 5-7-, 1930, that I last saw him alive on 5-7, 1930 and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

Arterial Sclerosis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5/6/30

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. Cushman, M. D.

, 19 (Address) Cornelian Bar

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn St. — DATE OF BURIAL May 11 1930

20 UNDERTAKER J. L. Brown & Son — ADDRESS 108 N Monty

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 57041

E 57041

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 N. Calhoun ST., 19-26 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Filomena Caldwell

(a) RESIDENCE NO. 535 N. Calhoun ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Enoch Caldwell

6 DATE OF BIRTH (month, day, and year) Jan 4 1878

7 AGE	Years	Months 4	Days 4	If LESS than 1 day, ... hrs. or ... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Enoch Caldwell

(Address) 535 N. Calhoun St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1930, to May 8, 1930, that I last saw h alive on May 8, 1930, and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH was as follows:

Cardiac Dropsy Valvular

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arthritis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles H. Frick, M. D.

May 9, 1930 (Address) 713 S. Mark Place

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL May 11 1930

20 UNDERTAKER H. A. Brown & Son

ADDRESS 108 W. Mosher

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57042

E 57042

100-601

CERTIFICATE OF DEATH.

13-59

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2141 Linden Ave. (ST.) (WARD)

2-FULL NAME Ida Stern

(a) RESIDENCE NO. 2141 Linden Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Solomon Stern

6 DATE OF BIRTH (month, day, and year) August 5th. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington, D.C.
(State or country)

PARENTS

10 NAME OF FATHER ? Oppenheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Stern
(Address) 2141 Linden Ave

15 MAY 10 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9th. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1930, to May 9, 1930, that I last saw h[illegible] alive on May 8, 1930, and that death occurred, on the date stated above, at 6.55 A.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Myocarditis (Congestive Cardiac failure (duration) - yrs. - mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis V. Hamburger, M. D.

, 19 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 5/11/ 1930

20 UNDERTAKER Harry Goodheim

ADDRESS 119 20 W. Mt. Royal Ave.

Cor.—10-10-29—A Co.—100 Bks.

E 57043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57043

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4803 Norwood St. 28-64 Ward)

2-FULL NAME Cora W. Sekes.

(a) RESIDENCE NO. 4803 Norwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Mulatto

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry L.

6 DATE OF BIRTH (month, day and year): Oct 15 1870

7 AGE: Years 59 | Months 6 | Days 25 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Va
(State or country)

PARENTS

10 NAME OF FATHER: Chas Wolfe.

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: Anne Fabell

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country)

14 Informant: Henry L. Sekes
(Address) 4803 Norwood St

15 Filed 1930 G. HAMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 " 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgery

(Signed) F. P. Gorsuch M. D.
Coroner
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D B

DATE OF BURIAL: May 12 1930

20 UNDERTAKER: H. C. Duncan

ADDRESS: Hagerstown Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-E 57044

E 57044

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hosp ST., 8th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Sewick

(a) RESIDENCE NO. 2522 E. Eager St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 11 mos. 10 ds. How long in U. S., if foreign birth? 9 yrs. 11 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	9	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER James Sewick

11 BIRTHPLACE OF FATHER (city or town) Balto City
(State or country)

12 MAIDEN NAME OF MOTHER Mary Struber

13 BIRTHPLACE OF MOTHER (city or town) Balto City
(State or country)

14 Informant James Sewick
(Address) 2522 E. Eager Street

15 Filed ..., 19... Registrar

C. HANSON JONES, M. D.

0 1930 Dpt.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 10, 1930; that I last saw h e r alive on May 10, 1930 and that death occurred, on the date stated above, at 6:45 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical picture

(Signed) Arthur Rattenni, M. D.

5/10, 1930 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 13 1930
20 UNDERTAKER	ADDRESS
August Tasch	2406 Bolton Ave

Spec.—8-16-29—L. F. S.—100 Bks.

2B4885 57045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 100-001 E 57045

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Roddey

(a) RESIDENCE NO. Atlanta Ga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret

6 DATE OF BIRTH (month, day, and year) Nov-7-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	53	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Frederic W.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ____ 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-9-1930

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1930, to May 9, 1930

that I last saw h[illegible]alive on May 9, 1930

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary oedema (a few hours) diffuse lobular pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia from aspiration of fluid (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? macroscopic exam.

(Signed) Ruth E Fairbank, M. D.

5/10. 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Atlanta, Ga.

DATE OF BURIAL May 12 1930

20 UNDERTAKER Wm. J. Tuckner & Son

ADDRESS E. North St Atlanta Ga

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 57046

CERTIFICATE OF DEATH

E 57046

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 538 Baker St., Ward 14-59

2-FULL NAME Josiah Payton

(a) RESIDENCE NO. 538 Baker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown.

6 DATE OF BIRTH (month, day, and year): 1890

7 AGE: Years 40 | Months | Days | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Security Storage
(c) Name of employer: Warehouse Co

9 BIRTHPLACE (city or town): Va
(State or country): "

PARENTS

10 NAME OF FATHER: Philip Payton

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country): "

12 MAIDEN NAME OF MOTHER: Lucy Robinson

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country): "

14 Informant: Susie Burrell
(Address): West Point Va

15 Filed ... 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 8th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Pneumonia

(Signed) J. Fitzgerald, M. D.

May 8 1930 (Address) Bradley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Court Co — DATE OF BURIAL: 5/10/30

20 UNDERTAKER: Samuel Hemsley — ADDRESS: 578 Madison

Pat

Upon DEATH of plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 E 001
E 57047

CERTIFICATE OF DEATH.

E 57047

REGISTERED NO. 57047

1-PLACE OF DEATH Sinai Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 27-54 ST. WARD)

2-FULL NAME Jacob Melnicoff

(a) RESIDENCE NO. Hebrew Aged Home ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Lisa Melnicoff

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) I. Lewis 1439 E Baltimore St

Filed MAY 1 1930 C. HALL JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10/30

17 I HEREBY CERTIFY, That I attended deceased from 4/28, 1930, to 5/10, 1930, that I last saw him alive on 5/10, 1930, and that death occurred, on the date stated above, at 8:40 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hebrew Aged Home

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical Examination

(Signed) Samuel J Stapleton M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave. DATE OF BURIAL 5-11-1930

20 UNDERTAKER I. Lewis, 1439 E Baltimore St ADDRESS

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57048

CERTIFICATE OF DEATH.

5 | E 57048

REGISTERED NO.

1-PLACE OF DEATH Sinai Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 13-54 ST. (WARD)

2-FULL NAME Mildred Blumberg

(a) RESIDENCE NO. 2400 Cedar ST., Plaza (WARD)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 16 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	13	3	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School - Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Meyer Blumberg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Anna Woodman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant Jack Lewis
(Address) 1439 E. Balto. St.

15 Filed 5-11 1930 C. BARRETT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/9/30

17 I HEREBY CERTIFY, That I attended deceased from 5/6/30, 19..... to 5/9/30 19.....,
that I last saw h[illegible]live on 5/9/30, 19.....,
and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:
Rheumatic Fever
Pericardial effusion

(duration) .....yrs. mos 4 wks ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? Balt.
Did an operation precede death? No Date of —
Was there an autopsy? No —
What test confirmed diagnosis? Physical Exam.

(Signed) L. H. Silver, M. D.
, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Levindale Hebrew Home — DATE OF BURIAL 5-11- 1930

20 UNDERTAKER Jack Lewis, 1439 E Balto St — ADDRESS

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57049 E 57049

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Sinai Hospital ST. 6-9 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rachael Goldman

(a) RESIDENCE NO. 1137 N Broadway ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widows

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Goldman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Morris Paul
(Address) 4006 Carroll Ave.

15 Filed MAY 11 1930 BALTIMORE CITY HEALTH DEPT. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10/30.

17 I HEREBY CERTIFY, That I attended deceased from 4-30, 1930, to 5-10, 1930, that I last saw h[illegible] alive on 5-10, 1930, and that death occurred, on the date stated above, at 2 32 p.m.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(duration) yrs. mos 4 ds.
CONTRIBUTORY (Secondary) Diabetes mellitus
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) B. J. Cohen, M. D.
5/9, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lucas Work Road
DATE OF BURIAL 5-11-1930
ADDRESS

20 UNDERTAKER Isaac Levin, 1739 E Balto St.

Cor.—10-10-29—A Co.—100 Bks.

57050

HEALTH DEPARTMENT—CITY OF BALTIMORE

17 VE 57050

CERTIFICATE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Sinai Hospital St., 4-18 Ward)

2-FULL NAME Katie Goldberg

(a) RESIDENCE NO. 1442 N. Eden St., St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	78			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknow

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Nathan Miller
(Address) 3411 Springdale Ave.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10th- 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Both broken legs & internal injuries. Jumped out of 3rd story window at Sinai Hospital. Suicide

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

5/10/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Northern Ave. DATE OF BURIAL 5-10- 1930

20 UNDERTAKER Jack Levin, 1439 E. Balto. St. ADDRESS

Be sure to write in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57051

CERTIFICATE OF DEATH

129

E 57051

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2551 Robb, ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph H. Robinson

(a) RESIDENCE NO. 2551 Robb ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily S. Robinson

6 DATE OF BIRTH (month, day, and year) July 21 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Geo. W. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant A. H. Biddlecomb

(Address) 2551 Robb

15 Filed MAY 1 1930, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1930

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to May 10, 1930, that I last saw him alive on May 10, 1930 and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uraemia

(Signed) Thos. F. A. Stevens, M. D.

5/10, 1930 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reedville Va

DATE OF BURIAL 5/11/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57052

CERTIFICATE OF DEATH.

31 E 57052

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals T.B. 6-10 (ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Joseph Navratil

(a) RESIDENCE NO. 11 N. Rose st. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Navratil

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Cyril Navratil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Czecho-Slavokia

12 MAIDEN NAME OF MOTHER Mary Roache

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Czecho-Slavokia

14 Informant Hospital Records (Address)

15 Filed MAY 1 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1929, to May 9, 1930, that I last saw him alive on May 9, 1930, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What (test confirmed diagnosis) Clinical

(Signed) M. D.

5-9, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 5/13/1930

20 UNDERTAKER Wm Cook 127 St Paul St

ADDRESS

Spec.—1-30—M. & T.—250 Blks

Dr. Murgatroyd Barclay 25 & 61

57053 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57053

90

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3020 Montebello Ave (Ward) 44

2-FULL NAME Charlotte Griegoleit

(a) RESIDENCE No. 3020 Montebello Ave St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~
~~HUSBAND~~ (or) WIFE of Julius Griegoleit

6 DATE OF BIRTH (month, day, and year) 6/16/1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Chas Link
(Address) 3020 Montebello Ave

15 Filed MAY 11 1930 H. [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10/30

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1930, to May 10th, 1930, that I last saw her alive on May 9th, 1930 and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) H. W. Yingling Army 1111 D, M. D.

5/10/1930 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 5/12/1930

ADDRESS St Paul et

UNDERTAKER D. Wm Cook 1217

Spec.—1-30—M. & T.—250 Blks

E 57054 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 E 57054

CERTIFICATE OF DEATH.

REGISTERED NO. 20-10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3340 Old Frederick Rd St.) (WARD)

2-FULL NAME Elizabeth Rebecca Reinwald

(a) RESIDENCE NO. 3340 Old Frederick Rd St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew

6 DATE OF BIRTH (month, day, and year) Aug 12 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
90	59	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christ Sengstock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude Hamm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Lizzie Sengstock 3340 Old Frederick Road

15 Filed MAY 11 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to May 9, 1930, that I last saw h alive on May 9, 1930, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy Exam

(Signed) F. T. Kyger, M. D.

, 19 (Address) 3321 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 5/12/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 57055

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57055

CERTIFICATE OF DEATH

REGISTERED NO. 9

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1116 (ST.) Scott (WARD) 21-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Deloris C. Klosmeier

(a) RESIDENCE NO. 1116 (ST.) Scott (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 If Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 14, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Carroll C. Klosmeier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga Md

12 MAIDEN NAME OF MOTHER: Deloris Grise

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Carroll C. Klosmeier

(Address) 1116 Scott St

15 Filed ....., 19..... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10. 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 5, 1930, to May 5, 1930, that I last saw h W alive on May 5, 1930, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Chas. H. Palmer M. D.

(Signed) 5/10, 1930 (Address) 300 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross S.A. Co.

DATE OF BURIAL: 5/12 1930

20 UNDERTAKER: William Cook

ADDRESS 2117 E. Fond St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57056 — REGISTERED NO. 129 E 57056

1-PLACE OF DEATH

City of Baltimore: (No. 4033 E. Lexington St.) (Ward 5-8)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Riley

(a) RESIDENCE NO. 4033 E. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Benjamin F. Riley

6 DATE OF BIRTH (month, day, and year) 4/15/1879

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	51	0	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer Self

9 BIRTHPLACE (city or town) Md.
(State or country) U. S.

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) [illegible]
(State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) [illegible]
(State or country)

14 Informant Mrs Riley
(Address) 4033 E. Lexington

15 Filed ....., 19....., [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular heart Disease

Contributory Cerebral Hemorrhage (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Kidney trouble (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. T. Riley, M. D.

5/11 19 30 (Address) 1053 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL 5/12/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 E 57057

CERTIFICATE OF DEATH

REGISTERED NO. E 57057

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 50 Bells Lane ST. 12-26 WARD)

2—FULL NAME Mrs. Gertrude Rose

(a) RESIDENCE NO. 2116 Barclay St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
(or) WIFE of Aplus D Rose

6 DATE OF BIRTH (month, day, and year) Nov. 5, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70 yrs.	5	5	

8 OCCUPATION OF DECEASED Housewife

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Howard O. Rose

(Address) 2116 Barclay St

15 Filed ..., 19... HAWKINS JONES, M. Registrar

For Cook

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10-1930

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to May 10, 1930, that I last saw h.... alive on May 10, 1930, and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows: Mesenteric Thrombosis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 5-10-30

Was there an autopsy? not

What test confirmed diagnosis? Mesenteric Thrombosis

(Signed) E. L. Lasseigne, M. D.

, 19 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 5/12/1930

20 UNDERTAKER Wm. Cook

ADDRESS 1217 St. Paul St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57058

CERTIFICATE OF DEATH

49

E 57058

REGISTERED NO. 25-61

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. 3616 Forest Park Ave. WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sevilla Charlotte Myers

(a) RESIDENCE NO. 3616 Forest Park ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Melanchton Myers

6 DATE OF BIRTH (month, day, and year): Jan 18 1861

7 AGE: Years 69 | Months 3 | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS
10 NAME OF FATHER: Noah F. Engle
11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland
12 MAIDEN NAME OF MOTHER: Eliza Koontz
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Harry A. Read
(Address) 3616 Forest Park Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9, 30

17 I HEREBY CERTIFY, That I attended deceased from April 24th 19 30, to May 9th 19 30,
that I last saw he alive on May 9th 19 30
and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:
Lymphosarcoma of the prostate & sacral glands
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Usual

(Signed) Henry K. Hill, M. D.
19 (Address) 3711 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Valley Cem.
DATE OF BURIAL: May 12 30

20 UNDERTAKER: A. S. Marshall
ADDRESS: 3537 Fait Ave

Spec.—1-10-21—M&T—1500 Bks.

E 57059

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57059

CERTIFICATE OF DEATH.

REGISTERED NO. 161-801

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No.) Calhoun & Lafayette ST. Md WARD 16-66

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Martin

(a) RESIDENCE NO. 633 Woodington Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Wht	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-8-30

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work newborn

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER James E Martin

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Miriam Keirig

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant James E Martin
(Address) 633 Woodington Ave

15 Filed MAY 1 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10- 1930

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 10, 1930, that I last saw him alive on May 10, 1930, and that death occurred, on the date stated above, at 1 40 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity (6 months)

(duration) — yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? History + age

(Signed) Ethel A Cohen M. D.

May 10/30 (Address) 2145 N Bal 4

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL May 12 1930

20 UNDERTAKER F Vernon Keehner

ADDRESS 1632 Hollins

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

Cieslak ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57060

CERTIFICATE OF DEATH.

117

E 57060

REGISTERED NO.

1-PLACE OF DEATH Balto City Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1-3 St., Ward)

2-FULL NAME George Cieslak

(a) RESIDENCE NO. 2529 Fait Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Cieslak

6 DATE OF BIRTH (month, day, and year) Jan 17, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown.

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Joseph Cieslak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. Runds. (Address)

15 Filed 1 7 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8/30

17 I HEREBY CERTIFY, That I attended deceased from 4-27, 1930, to 5-8, 1930, that I last saw h alive on 5-8, 1930, and that death occurred, on the date stated above, at 9.40 p m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

Generalized Peritonitis

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 4-27-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Fred M. Dunkerly, M. D.

5-9 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cemetery — DATE OF BURIAL May 17 1930

20 UNDERTAKER George A. Weber — ADDRESS 706 S. Ann st.

Spec.—8-16-29—L. F. S.—100 Bks. Wikarska Frank

E 57061

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45

E 57061

REGISTERED NO. 26-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6736 Youngstown ave ST., WARD)

2—FULL NAME Magdalena Wikarska

(a) RESIDENCE NO. 6736 Youngstown ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): July 12 - 1853.

7 AGE: Years 76 | Months 9 | Days 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Antoni Wikarski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Rev. Stanislaus Wikarski

(Address) 6736 Youngstown ave.

15 Filed ..... 19 ..... Registrar

HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/9/30

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1930, to May 9, 1930, that I last saw h[illegible] alive on May 9, 1930 and that death occurred, on the date stated above, at 10.55 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of duodenum.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P.S. & Symptoms

(Signed) John V. Segerbrehi, M. D.

19 (Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart of Mary

DATE OF BURIAL: May 13 1930

20 UNDERTAKER: George A. Weber

ADDRESS: 705 S. Ann St

Spec.—8-16-29—L. F. S.—100 Bks. Ludwika Tyma

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 57062

CERTIFICATE OF DEATH

E 57062

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 408 S Chapel st ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ludwika Tyma

(a) RESIDENCE NO. 408 S Chapel st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 10 - 1852

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
77	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Piechowiak

11 BIRTHPLACE OF FATHER (city or town) Poland.
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland.
(State or country)

14 Informant Henry Leifert
(Address) 408 S Chapel st.

15 Filed MAY 12 1930 HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9/30

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1930, to May 9th, 1930, that I last saw h.. alive on May 9th, 1930 and that death occurred, on the date stated above, at 11 40 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Cobel V Athey, M. D.

May 10th, 1930 (Address) 100 S. Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cemetery

DATE OF BURIAL May 12 1930

UNDERTAKER George A Weber

ADDRESS 708 S. Ann st

Cor.—10-10-29—A Co.—100 Bks.

E 57063

HEALTH DEPARTMENT—CITY OF BALTIMORE

Burnham E ~~57063~~

CERTIFICATE OF DEATH

185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1107 E Balto St., 25 Ward)

2-FULL NAME Geo Samuel Burnham

(a) RESIDENCE NO. 1107 E Balto St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo W.

6 DATE OF BIRTH (month, day, and year) July 30 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	61	9	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant (Address) Geo. W. Burnham 1107 E Balto St

15 Filed APR 11 1930 H. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9- 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows: Acc Fall off Stool
Fractur of Right Ribs -
(duration) yrs. mos. 7 da.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? — —
Did operation precede death? — Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. C. Clarke M. D.
(Address) 1516 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Immanuel Cemetery

DATE OF BURIAL 5/12 1930

20 UNDERTAKER Jos Lurman & Bro

ADDRESS 1127 E Balto St

important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

236590 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57064 CERTIFICATE OF DEATH 51 E 57064

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 5-9 WARD) E

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hettie Peterbursky

(a) RESIDENCE NO. 217 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec-31-1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or estsblishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Isadore Peterbursky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Friedman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records

(Address)

15 Filed 19 Registrar

HAMPSON JONES, M. D.

MAY 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-9-30

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 9, 1930

that I last saw her alive on May 9, 1930

and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis
Myocardial Failure

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hedwig Kaveeg, M. D.

5/9 1930 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 5/11 1930

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 112 E Baltimore St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57065

CERTIFICATE OF DEATH

90 E 57065

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3306 Gibbons Ave St., 27-44 (Ward))

2-FULL NAME Mary Cunningham

(a) RESIDENCE NO. 3306 Gibbons Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	~~widow~~

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Thos Cunningham

6 DATE OF BIRTH (month, day, and year) Dec 6/1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59	5	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Midwife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

0 8 6

9 BIRTHPLACE (city or town)
(State or country) Ireland

PARENTS

10 NAME OF FATHER Douggan Gregory

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Irelamd

12 MAIDEN NAME OF MOTHER Mary Hastery

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant John J. Cunningham
(Address) 3306 Gibbons Ave

15 Filed ....., 19..... Registrar

MAY 11 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. H. Cullen, M. D.

5/10/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 1930
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	2242 E.

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 57066 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57066

CERTIFICATE OF DEATH. 129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Montpelier ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick J. Hynes

(a) RESIDENCE NO. 616 Montpelier ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Honora Hynes

6 DATE OF BIRTH (month, day, and year): May 17, 1860

7 AGE: Years 70 | Months 1 | Days 22 | If LESS than 1 day.... hrs. or.... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cooper 015

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer: Kingan Provison

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John J. Hynes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Henry Costigan (Address) 616 Montpelier St.

15 Filed MAY 11 1930, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9 1930

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1930, to May 9, 1930, that I last saw h[illegible] alive on May 9, 1930, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

From personal knowledge

(duration) yrs. mos 47 ds.

CONTRIBUTORY (Secondary) Chr Pancreatitis Nephritis

(duration) yrs. months ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Owen E Woodruff, M. D.

May 9, 1930 (Address) 130 E. North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: May 12, 1930

20 UNDERTAKER: Edmund W. Conklin ADDRESS 924 E. Eager St.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 57067

REGISTERED NO.

E 57067

1-PLACE OF DEATH

City of BALTIMORE: (No. Manchester apts St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Hexter

(a) RESIDENCE NO. Madison ave Bloom St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Hexter

6 DATE OF BIRTH (month, day, and year): Aug 3 - 1847

7 AGE: Years 82 Months 9 Days 7

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Henry Hexter

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rachel Hadecker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs M Affleder (Address) Manchester Apts

15 Filed MAY 11 1930, 19 Registrar RML

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 - 1930

17 I HEREBY CERTIFY, That I attended deceased from May 19 29 to May 10 1930, that I last saw her alive on May 10 1930, and that death occurred, on the date stated above, at 6.20 PM.

The CAUSE OF DEATH* was as follows:

arteio - sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I Frederick Lentz, M. D.

5-11, 1930 (Address) Temple Gardens apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

Date of Burial 5/12 1930

20 UNDERTAKER: J A Krem & Co

ADDRESS 1732 Pennsylvania Ave

Hebrew Friendship Cem

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-30—M. & T.—200 Bks.

E 57068

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57068

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (NO. ..... ST. 25-77 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bacwnski (Bacwinski)

(a) RESIDENCE NO. 1600 Pennington ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) June 17, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER William Bacwnski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records

(Address) .....

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1930, to May 8, 1930, that I last saw him alive on May 8, 1930, and that death occurred, on the date stated above, at 11.55 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos Gbrnoes Jr, M. D.

5-9, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a A Co — DATE OF BURIAL May 12 1930

20 UNDERTAKER F. W. Ozgewski — ADDRESS 1730 Eastern

Spec.—8-16-29—L. F. S.—100 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57069 — CERTIFICATE OF DEATH — 90 — E 57069

REGISTERED NO. 27-54

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6004 Falls Road ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susan R. Sewell

(a) RESIDENCE NO. 6004 Falls Road ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan T. Sewell

6 DATE OF BIRTH (month, day, and year) Jan 17-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER John F. Hickey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Delphia Carney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Bessie A. Small

(Address) 6004 Falls Road

15 Filed ..., 19 ... C. HARRISON JONES, JR. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9-1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb., 1930, to May 9, 1930, that I last saw h— alive on May 8, 1930 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Endocarditis, Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. H. Martin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Ivy Hill, Laurel, Md. DATE OF BURIAL May 12 1930.

20 UNDERTAKER Horace F. Burgee ADDRESS 3631 Falls Road

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57070

E 57070

CERTIFICATE OF DEATH.

146

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt. General Hospital (Street) (Ward)

2-FULL NAME Mrs. Mary Smith.

(a) RESIDENCE NO. 735 Edgewood St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mike A. Joseph Smith

6 DATE OF BIRTH (month, day, and year): March 25, 1908

7 AGE: Years 22 yrs. Months 1 Days 16

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Felix B. Candrey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Martha Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hospital Records

(Address)

15 Filed MAY 1 1930 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/10/30 '19

17 I HEREBY CERTIFY, That I attended deceased from 4/22/30 19..... to 5/10/30 19..... that I last saw her alive on 5/10/30 19..... and that death occurred, on the date stated above, at 4:20 p. m.

The CAUSE OF DEATH* was as follows:

Child birth -

PUERPERAL (duration) yrs. mos. 18 ds.

Pneumonia Streptococcus Septicemia (Secondary) (duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

5/10/30 (Signed) Jno A. Lamb Jr. M. D.

(Address) Mt. Hope Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: May 13 1930

20 UNDERTAKER: Geo M. Little

ADDRESS 2700 Edmondson

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57071

CERTIFICATE OF DEATH.

101-001

57071

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (WARD) 1-13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmore Blackwell

(a) RESIDENCE NO. 911 N. Dallas ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adelaide Blackwell

6 DATE OF BIRTH (month, day, and year) June 9 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) 986

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Whiteboro Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Adelaide Blackwell

(Address) 911 N. Dallas St.

15 Filed 1-1-1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9. 1930

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to May 9, 1930, that I last saw h alive on May 9, 1930, and that death occurred, on the date stated above, at 8 30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? clinical + Autopsy

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grandy Va.

DATE OF BURIAL 5/11/1930

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1631 Druid Hill

C. HAMPTON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 57072

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57072

CERTIFICATE OF DEATH.

162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St. 45-59 WARD)

2-FULL NAME Baby Dichler

(a) RESIDENCE NO. 2007 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 30 min.
Newborn				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin Dichler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Tamara Wagenheim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hosp. Record

(Address)

15 Filed MAY 11 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 10, 1930,

that I last saw h[illegible] alive on May 10, 1930,

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows: (Coroner)

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dystocia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. E. Goodman, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Park & Herman Hill Road — DATE OF BURIAL 5-11- 1930

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St.

Spec.—1-30—M. & T.—250 Blks.

E 57073 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57073

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 4-1 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Sellman (or Sullivan)

(a) RESIDENCE NO. Henryton Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 12 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
67	68	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Sellman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Brandenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eugene Sellman (Address) Henryton Md.

15 Filed 1-1 1930 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10-30

17 I HEREBY CERTIFY, That I attended deceased from 5-1, 1930, to 5-10, 1930, that I last saw h[illegible]live on 5-10, 1930, and that death occurred, on the date stated above, at 9.26 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic cardiovascular disease

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyko, M. D.

5/10, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. View Cemetery

DATE OF BURIAL May 13 1930

20 UNDERTAKER Deer & Son Dun

ADDRESS Sykesville Md.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57074 ✓ 44 E 57074

REGISTERED NO. E 57074

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 Aisquith Street ST., 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sr. M. Ubaldina Mc. Entee

(a) RESIDENCE NO. Convent of Notre Dame ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer School Sisters of Notre Dame Philadelphia Co.

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Patrick Mc. Entee

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Agnes Haynes

13 BIRTHPLACE OF MOTHER (city or town) England (State or country)

14 Informant School Sister of Notre Dame (Address)

15 Filed ... 19 ... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1928, to May 10, 1930, that I last saw h.... alive on May 10, 1930, and that death occurred, on the date stated above, at 11.35 a.m.

The CAUSE OF DEATH* was as follows:

Inoperable Carcinoma

Stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual one

(Signed) F. J. Kirby, M. D.

5/10, 1930 (Address) 110 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notch Cliff

DATE OF BURIAL 5/12/30

20 UNDERTAKER Frank A. Fink

ADDRESS 915 N Gay St

Spec.—1-30—M & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001

E 57075

CERTIFICATE OF DEATH.

E 57075

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (St.) 7-13 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Courtney

(a) RESIDENCE NO. 731-N-Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Lizzie Courtney

6 DATE OF BIRTH (month, day, and year): 1876

7 AGE: Years 54 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Lizzie Courtney (Address) 731 N Wolfe

15 Filed 12 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-11-30

17 I HEREBY CERTIFY, That I attended deceased from 4-22-, 1930, to 5-11-, 1930, that I last saw him alive on 5-11-, 1930, and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

Perforating ulcer colostomy

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 1928

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Beachem, M.D.

11, 1930 (Address) 1 Boonsboro

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 5-12 1930

20 UNDERTAKER: Leonard Graham

ADDRESS 916 Pine

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57076

E 57076

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2414 Mace St. (Ward) 12-51

2-FULL NAME David Hamilton

(a) RESIDENCE NO. 2414 Mace St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How lung in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Leroy Hamilton
(Address) 2414 Mace St

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by me (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis
of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

5/10 1930 (Address) 9672 Reisterstown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-11-1930
20 UNDERTAKER	ADDRESS
Daniel Carlon	Pikesville

Important: See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57077

E 57077

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1858 Andre St. St., 24-35 Ward)

2-FULL NAME Peter Werzendorf.

(a) RESIDENCE NO. 1858 Andre St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, HUSBAND of Elizabeth Werzendorf

6 DATE OF BIRTH (month, day, and year) September 28, 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	61	7	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Hungary.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Elizabeth Werzendorf. (wife)
(Address) 1858 Andre St.

Filed ..... 19.. C. HAMPSON GIBBS, M. D. Registrar

MAY 12 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9th. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said inquiry (Inquest, autopsy, or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Hemiblegia.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What tests confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, M. D.

5/10. 1930 (Address) 815 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross.

DATE OF BURIAL 5/12/1930

20 UNDERTAKER Edward Foulke

ADDRESS 2302 Guilford Ave

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks. Charaklea Bellos E 57078

E 57078 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 10-15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 Brentwood AVE. (or ST.), 10 WARD)

2-FULL NAME Charaklea Bellos

(a) RESIDENCE NO. 1212 Brentwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Philip Bellos

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Philip —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Philip Bellos (Address) 1212 Brentwood Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10-1930

17 I HEREBY CERTIFY, That I attended deceased from 4-24-1930, to 5-10, 1930

that I last saw h[illegible] alive on 5-10, 1930

and that death occurred, on the date stated above, at 7:4 a.m.

The CAUSE OF DEATH was as follows:

General arterio Sclerosis.

Diabetes Mellitus.

(duration) ? yrs. — mos ... ds.

CONTRIBUTORY (Secondary) Myocarditis.

(duration) ... yrs. ... mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) S. Abrunez M.D.

5-11, 1930 (Address) Medical arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 5-12 1930

ADDRESS 916

UNDERTAKER David Easter & Sons

Spec.—1-10-21—M&T—1500 B

E 57079

E 57079

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1539 W.Lanvale St 16-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Hare

(a) RESIDENCE NO. 1539 W.Lanvale St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of HUSBAND of Husband of E.Rosa Hare

6 DATE OF BIRTH (month, day, and year) Aug 7 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationery Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer Has not worked in 4 Years

9 BIRTHPLACE (city or town) (State or country) State of maryland

PARENTS

10 NAME OF FATHER John Hare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant E.Rosa Hare (Address) 1539 W.Lanvale St

15 Filed 12 1930 19 C. HA[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May.9.1930 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 1926 to May 9 1930 19 to 19 that I last saw him alive on May 8 1930 19 and that death occurred, on the date stated above, at 11 AM. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) 4 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Secondary Cerebral Hemorrhage

May 5 1930 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? tom Clinical Symp-

(Signed) Charles E. Reark M. D.

May 11 1930 (Address) 3214 Piedmont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem DATE OF BURIAL 5-12-30

20 UNDERTAKER Daniel Easton ADDRESS 96 Pa ave

Spec.—1-10-21—M&T—1500 Mss.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57080

101-001

E 57080

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 621 W. Biddle ST. 17-24 WARD)

2-FULL NAME James B. Tabb

(a) RESIDENCE NO. 621 W. Biddle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 20-1905

7 AGE: Years 25 Months ..... Days 20 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr Michael.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Tabb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Weston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Martha Tabb 622 Baltimore St.

15 Filed MAY 21 1930 C. HAMPTON JONES, R. D. 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1930

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 10, 1930, that I last saw him alive on May 9, 1930, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Mary Strong, M. D.

May 10 1930 (Address) 729 Park Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem.

DATE OF BURIAL: 5/12 1930

20 UNDERTAKER: Chas Alexander 1406

ADDRESS: Denmead (illegible)

PRINTED IN U.S.A. Read instructions carefully. They are important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 57081

E 57081

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 5522 Belair Road St. 27-42 (Ward)

2-FULL NAME Edward P. Kraeter

(a) RESIDENCE NO. 5522 Belair Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Louisa S. Kraeter

6 DATE OF BIRTH (month, day, and year) Mar 13/1881

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	1	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Confectionary
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Philip Kraeter

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Kohler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New York.

14 Informant Louisa S. Kraeter
(Address) 5522 Belair Road

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

1930 RML

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

5/10/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL May 11 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

101-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57082

REGISTERED NO. E 57082

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 Eislen ST. 21-29 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Nannie Smith

(a) RESIDENCE NO. 735 Eislen ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Smith

6 DATE OF BIRTH (month, day, and year): apr. 15, 1883

7 AGE: Years 47 | Months — | Days 24 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wife, Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Virginia

10 NAME OF FATHER: James Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Virginia

12 MAIDEN NAME OF MOTHER: Ida Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond Virginia

14 Informant: Elizabeth Brown

(Address) 1401 W Franklin

Filed MAY 12 1930 19 A. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/9/30

17 I HEREBY CERTIFY, That I attended deceased from 5/4, 1930, to 5/9, 1930, that I last saw h[illegible] alive on 5/8, 1930 and that death occurred, on the date stated above, at 3:10 P.M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary): Bronchial asthma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinic

(Signed) Dan Cruchen, M. D.

5/10, 1930 (Address) 122 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Treas

DATE OF BURIAL: May 13 1930

20 UNDERTAKER: Joseph A Lively

ADDRESS 4092 Mount St

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57083 Duplicate 112 E 57083

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 509 Morris St., 19-27 Ward)

2-FULL NAME Aneta Ruda Lomax Liggins

(a) RESIDENCE NO. 509 Morris St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Wash.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Elise Speeks
(Address) 509 Morris St

15 Date May 7 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) few hours

CONTRIBUTORY (Secondary) Error of Diet

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Beverley Gladden M. D. Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

DATE OF BURIAL May 5 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

Important: See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 57084 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57084

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1122 S. Paca St. ST. 21-29 (WARD)

2-FULL NAME Catherine F. Knapp

(a) RESIDENCE NO. 1122 S. Paca St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Benjamin F. Knapp

6 DATE OF BIRTH (month, day, and year) Oct. 30, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Easter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Weiland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Ford (Daughter)

(Address) Essex, Md.

15 Filed MAY 12 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to May 9, 1930, that I last saw her alive on May 9, 1930, and that death occurred, on the date stated above, at 6.30 pm.

The CAUSE OF DEATH* was as follows:

Diabetes

Mellitus (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Trimmer, M. D.

5-12, 1930 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

DATE OF BURIAL 5/12/30

20 UNDERTAKER Harry N. Mitzel, 410 Edmondson Ave.

ADDRESS

Spec.—1-12-23—M&T—500 Blks.

E 57085

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57085

CERTIFICATE OF DEATH.

101-20

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 N. Bond St. 6-9 WARD)

2-FULL NAME Charles Yong

(a) RESIDENCE NO. 415 N. Bond St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret Magdalene Yong

6 DATE OF BIRTH (month, day, and year) Aug. 11 1860

7 AGE: Years 29 / 30 — Months 8 — Days 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saloon Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town) (State or country) Zebulon N. C.

PARENTS

10 NAME OF FATHER Richard Yong

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary Harbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

Informant (Margaret Magdalene Yong)
(Address) 415 N Bond St

Filed 12 1939 — 19 Recorded

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-4- , 1930 , to 5-10- , 1930 ,

that I last saw h[illegible] alive on 5-10- , 1930 ,

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Pitt Cargill, M. D.

11- 1930 (Address) 611 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Zebulon N C — DATE OF BURIAL: May 12 1930

20 UNDERTAKER: [illegible] Wilkins — ADDRESS: 1515 McElderry St

C. HA[illegible]

Spec.—1-30—M. & T.—250 Bks

E 57086

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57086

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1834 Wilkens Ave. W. 4-28 WARD)

2-FULL NAME Elizabeth Bergen

(a) RESIDENCE NO. 1834 Wilkens Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 9 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emil Bergen

6 DATE OF BIRTH (month, day, and year) July 11, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Henry C. Bergen

(Address) 1834 Wilkens Ave

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 28, 1930, to May 9, 1930,

that I last saw h alive on May 7, 1930,

and that death occurred, on the date stated above, at 8:45 p m.

The CAUSE OF DEATH* was as follows: ' '

Chronic Interstitial Nephritis

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Cardiac Dilation

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. C. Triplett, M.D.

, 19 (Address) 1324 N. Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL May 12 1930

ADDRESS

20 UNDERTAKER Mr. Mrs. John W. Teufel & Son 801 W. Fayette

Spec.—1-30—M. & T.—250 Bks

E 57087

57087

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 24-329

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 Battery ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna R. Kann

(a) RESIDENCE NO. 1226 Battery ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 7 mos. 13 da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Kann.

6 DATE OF BIRTH (month, day, and year) Sept 27-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	7	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 027

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Nicholaus Hirshing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Maier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jacob Kann.

(Address) 122 Battery ave.

15 Filed MAY 12 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 18th, 1929, to May 10th, 1930,

that I last saw h e alive on May 7th, 1930,

and that death occurred, on the date stated above, at 9.50 A.m.

The CAUSE OF DEATH* was as follows:

Chronic aortic regurgitation

of heart

(duration) 1 yrs. — mos 22 da.

CONTRIBUTORY (Secondary) Chronic interstitial Nephritis

(duration) — yrs. 6 mos. — da.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Storm Kerbel, M. D.

5/11, 1930 (Address) 1224-26 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL May 13 1930

20 UNDERTAKER Mrs. John K. Teufel & Son

ADDRESS 824 W. Fayette

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

57088

5 | V E 57088

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST. 22-30 WARD)

2-FULL NAME James Blackburn

(a) RESIDENCE NO. 620 W. Conway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	colored	infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8 1925

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	10	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Alvin Blackburn

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Thelma Bryant

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Clara Bryant
(Address) 620 W. Conway

15 Filed ..... 1930 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-11-30, 1930, to May 8, 1930, that I last saw h.. alive on May 8, 1930, and that death occurred, on the date stated above, at 4 10 p. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) ..... yrs. about 3 wks ds.

CONTRIBUTORY (Secondary) Acute Rheumatism

(duration) ..... yrs. 1½ mos. ..... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL May 12 1930

20 UNDERTAKER Samuel K Hensley

ADDRESS 1128 Bdwy

Spec.—1-30—M. & T.—250 Blks

Dr Nibbelt 2020 Garrison Blvd

E 57089 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57089

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3014 Prestman St. 16-67 WARD)

2-FULL NAME Margaret Sanders

(a) RESIDENCE NO. 3014 Prestman ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND ~~of~~ (or) WIFE of James W. Sanders

6 DATE OF BIRTH (month, day, and year) 11/5/1876

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Conrad Hoffman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Laura McCann

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant J. B. Hodinott
(Address) 3014 Prestman st

Filed MAY 12 1930 C. HARRISON JONES, M.D. Registrar
By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10/1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1930, to May 10, 1930, that I last saw h~~e~~r alive on May 10, 1930, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Inoperable Carcinoma of Uterus-bladder-rectum.

About duration from history about 1 yr.
(duration) about 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Inoperable carcinoma of Uterus (duration) about 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory test

(Signed) Walter Gilbert, M. D.

May 11 1930 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 5/13/1930

20 UNDERTAKER Wm Cook 1217 St Paul St

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57090

E 57090

186-105

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH (Ward) John Hopkins Hosp 2-

City of Baltimore: (No.) 200 E Pratt St Ward

2-FULL NAME Jessie Korman

(a) RESIDENCE NO. (Usual place of abode) St., Ward

Length of residence in city or town where death occurred (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20-1925

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	5	3	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Gador Korman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Fine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Hosp Records (Address)

15 Filed 12 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down by moving auto

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Front of 2034 Pratt

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

5/11 1930 (Signed) H. Stance, M. D.

(Address) 2134 E Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 5-12-1930

20 UNDERTAKER Jac Levin

ADDRESS 1412 E Balto

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57091

CERTIFICATE OF DEATH

31

E 57091

REGISTERED NO.

1—PLACE OF DEATH South Baltimore Gen. Hospital
CITY OF BALTIMORE (No. ST., WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME May L. Williamson ~~Rodgers~~ Rogers

(a) RESIDENCE NO. 818 N. Calvert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Rogers Jr.

DATE OF BIRTH (month, day, and year) Feb. 7, 1906

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	24	3	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer So. Balto. Gen. Hosp.

BIRTHPLACE (city or town) (State or country) N.C.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Joseph H. Rogers Jr.
(Address) 1330 Light St.

Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-8-30

17 I HEREBY CERTIFY, That I attended deceased from 5-8, 1930, to 5-8, 1930, that I last saw her alive on 5-8, 1930, and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous Pneumonia

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Physical Signs

What test confirmed diagnosis?

(Signed) Joseph Lauckaitis, M. D.

19 (Address) South Balto Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL May 12, 1930

20 UNDERTAKER Margaret E. Flynn — ADDRESS 1422 Light St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57092

CERTIFICATE OF DEATH.

E 57092

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. ..... WARD) 7-37

2-FULL NAME William Crawford

(a) RESIDENCE NO. 3902 Hudson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John B. Crawford
11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.
12 MAIDEN NAME OF MOTHER Minnie Kraus
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant John B. Crawford
(Address) 3902 Hudson St.

15 Filed 1 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 — 9 — 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-7-30, 19..., to 5-9-30, 19..., that I last saw him alive on 5-9-30, 19..., and that death occurred, on the date stated above, at 7.00 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X-Ray

(Signed) M B Burdett M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL 1st Evangelical Cemetery

DATE OF BURIAL May. 12. 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore St. & Broadway.

Spec.—1-30—M. & T.—250 Bks.

(Thelma Hammann)

E 57093 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 57093

CERTIFICATE OF DEATH.

REGISTERED NO._____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Baltimore My ST. 8-17 WARD)

2-FULL NAME Thelma Hamann

(a) RESIDENCE NO. 1835 N. Regester ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) May 30 28

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	1	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robt L. Hammann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Honora V. Clemens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Robt L. Hammann 1835 N. Regester St

15 Filed 1930 G. HA[illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10-30

17 I HEREBY CERTIFY, That I attended deceased from 4/21, 1930, to 5/10, 1930, that I last saw h[illegible] alive on 5/10, 1930, and that death occurred, on the date stated above, at 8-30 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage (Immediate)
Pulmonary Infarct Rt.
Pulmonary abscess Rt.
Pleural Empyema, Rt. (duration) ____ yrs. ____ mos. 3 wks.

CONTRIBUTORY (Secondary) Bronchio Pneumonia, Rt. (duration) ____ yrs. ____ mos. 1½ wks. ____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Benj Kleitz, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 5/13 1930

20 UNDERTAKER Philip Herwig — ADDRESS 2006 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57094

CERTIFICATE OF DEATH.

117 E 57094

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital 26-37 WARD

2-FULL NAME Christina Fetz

(a) RESIDENCE NO. 408 S. Oldham ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael P. Fetz

6 DATE OF BIRTH (month, day, and year) June 15 [illegible]

7 AGE: Years 28 | Months 10 | Days 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Adam Lang

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Richter

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant Michael P. Fetz Husband

(Address) 408 S. Oldham St

15 Filed 1 2 1930 19 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/9/30 19

17

I HEREBY CERTIFY, That I attended deceased from 4/10/30, 19, to 5/9/30, 19.

that I last saw him alive on 5/9/30 19,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

acute appendicitis and peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) intestinal obstruction

(duration) yrs. mos. 18 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/10/30 5/9/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Hendricks, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 10th 1930

20 UNDERTAKER Lilly & Sons

ADDRESS [illegible]

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57095

E 57095

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 23-31 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Smith

(a) RESIDENCE NO. 146 W. Cross st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Nickolas Smith

7 DATE OF BIRTH (month, day, and year) 1884 (?)

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46 (?)			

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Fred Schmidt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Minnie Kregar

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

Informant Hospital Records
(Address)

Filed MAY 12 1930 HARRISON JONES
Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to May 9, 1930, that I last saw her alive on May 9, 1930, and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. Schmidt Jr., M. D.

5-9 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Matthews Cem.

DATE OF BURIAL May 12 1930

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57096

CERTIFICATE OF DEATH

E 57096

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph's Hosp 10-14 St., Ward)

2-FULL NAME Thelma Coles

(a) RESIDENCE NO. 1418 E. Chase St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	C.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 5, 1925

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	5	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Burtis Coles

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Annie Peal

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N.C.

14 Informant Annie Coles
(Address) 1418 E. Chase St.

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns over almost entire body.
Clothes accidently caught fire while playing with matches in yard of home. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. T. Bauer, M. D.

5/12/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL May 12 1930

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1720 Ashland Ave

Spec.—1-30—M. & T.—250 Bks

E 57097

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57097

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1803 E. Chase ST. 7-13 WARD)

2-FULL NAME Elizabeth N. Myers

(a) RESIDENCE No. 1803 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of William E. Myers

6 DATE OF BIRTH (month, day, and year) March 29-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

10 NAME OF FATHER Lawrence Krug

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Sophia Klein

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Mrs Mary E. Reinhardt

(Address) 1114 N. Rutland ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to May 10, 1930.

that I last saw her alive on May 7, 1930.

and that death occurred, on the date stated above, at 6:25 P.M. E.S.T.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 7 mos da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fritz J Klinger, M. D.

5/11, 1930 (Address) 2700 Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL May 13, 1930

20 UNDERTAKER Chas S. Black & Sons

ADDRESS W. Fayette

Spec.—1-30—M. & T.—250 Bks.

57098

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 E 57098

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 16-68 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Florence Lambert

(a) RESIDENCE NO. 2805 Mosher St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 9 mos. 10 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of or) WIFE of Benjamin T. Lambert

6 DATE OF BIRTH (month, day, and year) August 1, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land

PARENTS

10 NAME OF FATHER John E. Bromwell

11 BIRTHPLACE OF FATHER (city or town) Dorchester (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret H. Tall

13 BIRTHPLACE OF MOTHER (city or town) Dorchester Co. (State or country) Maryland

14 Informant Benjamin T. Lambert

(Address) 2805 Mosher Street

MAY 12 1930 C. H. JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/11/30

17 I HEREBY CERTIFY, That I attended deceased from 5/3/30, 19..., to 5/11/30, 19..., that I last saw h alive on 5/11/30, 19..., and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ...yrs. ...mos ...ds.

CONTRIBUTORY (Secondary) (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Turner, M. D.

5/11/30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 5/11 19 30

20 UNDERTAKER: Henry W. Weaver & Son — ADDRESS: 525 W. Calvert

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57099

188-103

REGISTERED NO. E 57099

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 57099
1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp (ST.) 10-1st (WARD)

2-FULL NAME Phillip J. Ackerman

(a) RESIDENCE NO. 904 N Central ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) 4-3-1870

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	1	7	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Advertising Agent
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Md

10 NAME OF FATHER Jno B Ackerman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Frances E. Keller

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

Informant Mrs. Anna E. Ackerman
(Address) 904 N. Central Ave

Filed 5-11 1930 G. HAMPTON JONES, M. D. Registrar

Reg. No. 1939

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down by motor auto while crossing street at intersection

CONTRIBUTORY (Secondary) Crushed Chest. Multiple fracture (duration) yrs. mos. ds.
pelvis - Prof. Loss of (Duration) Emphysema (Duration) ds.

18 Where was disease contracted if not at place of death? North ave Freemont

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Frame Coroner M. D.

5-11 1930 Address 2939 W Eldery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL May 13 1930

20 UNDERTAKER Henry Woelfl Sons, Inc.

ADDRESS 130 E Eager St

Cor.—10-10-29—A Co.—100 Bks.

E 57100

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57100

31

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 932 S. Eutaw St. St., 21-29 Ward)

2-FULL NAME Ernest Pettiford. (C)

(a) RESIDENCE NO. 932 S. Pace St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jane Pettiford. (C)

6 DATE OF BIRTH (month, day, and year) December 28, 1899.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	30	4	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Pettiford. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Louise Fich. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Louise Pettiford. (C) mother.
(Address) 932 S. Eutaw St.

15 Filed 12 1930 19 HARRISON JONES M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto E. Reinhardt, M. D.

12/12, 1930 (Address) 101 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Albion Cemtry

DATE OF BURIAL 12/13, 1930

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1349 W. Baltimore St.

Spec.—1-30—M. & T.—250 Bks.

E 57101

E 57101 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 90

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 2128 Eagle ST., 20-28 WARD

2-FULL NAME Mary M. Gloag

(a) RESIDENCE NO. 2128 Eagle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David M. Gloag

6 DATE OF BIRTH (month, day, and year) Sept 19th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Pa

(State or country)

10 NAME OF FATHER John Seibert

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Mary A Stephens

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Mrs. D. K. Lyons

(Address) 2128 Eagle St

Filed MAY 12 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11/30

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 11, 1930, that I last saw h[illegible] alive on May 11, 1930, and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows: Hemiplegia — Myocarditis

(duration) yrs. mos. 11 da.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert C Peters, M. D.

19 (Address) 2128 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL May 12 1930

UNDERTAKER Westport ADDRESS 1850 N. Balto St

Spec.—1-12-23—M&T—500 Blks.

E 57102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 57102

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1308 Carey ST. 15-23 (WARD)

2-FULL NAME Elizabeth Jones

(a) RESIDENCE NO. 1308 Carey ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Jones

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Pajan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Amanda Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Martha L. Thomas

(Address) 120 Nelson

15 Filed 5-12 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/9 1930

17 I HEREBY CERTIFY, That I attended deceased from 5/5, 1930, to 5/9, 1930, that I last saw h[illegible] alive on 5/7, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis & Uremia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

5/9, 1930 (Address) 2134 Dill. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL 5-18-1930

20 UNDERTAKER Thos G. Bailey — ADDRESS 1421 Jefferson st

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57103

CERTIFICATE OF DEATH

90 ✓

E 57103

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1813 E. Port St., 8-16 Ward)

2-FULL NAME Henry Sippel

(a) RESIDENCE NO. 1813 N. Port St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Sippel

6 DATE OF BIRTH (month, day, and year) Sept 7/1860

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	09	8	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Henry Sippel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Catherine Sippel
(Address) 1813 N. Port St.

15 Filed ..... 19..1.. C. HARRY JONES M. D. Registrar

MAY 2 1930 Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Walker, M. D.

5/12/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL May 13 1930

20 UNDERTAKER Frank Evach & Son ADDRESS 1906 Oakland

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57104

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp 6-37 WARD)

2-FULL NAME Stanley Geist

(a) RESIDENCE NO 1 Miller Island Rd ST., Balto Co WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, Divorced (write the word)
M	W	Don't know

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Don't know

DATE OF BIRTH (month, day, and year) Don't know

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	Don't	know		

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Don't know
(b) General nature of industry, business, or establishment in which employed (or employer) know
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Don't know

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't know

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

Informant .....

(Address) .....

Filed MAY 12 1930 C. HARRY JAMES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows: Auto accident in which he was a rider forced from road by another auto overturning

CONTRIBUTORY (Secondary) Fract C C Spine (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Rise Ave nr Bear Creek

Did an operation precede death? yes Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Surg

(Signed) H. Grant Elderdice, M. D. Coroner

5/1, 1930 (Address) 2439 E Eager

* State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. ADDRESS MAY 12 1930

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 E 57105

REGISTERED NO. E 57105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 E Biddle ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Dowd

(a) RESIDENCE NO. 904 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Dolan

7 DATE OF BIRTH (month, day, and year) Nov. 29/77

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	53		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Park warden

(b) General nature of industry, business, or establishment in which employed (or employer) City Park

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Edw. Dowd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mrs. Chas. Dowd

(Address) 433 E. Chase

Filed May 13 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10/30.

17 I HEREBY CERTIFY, That I attended deceased from 5/6, 1930, to 5/10, 1930, that I last saw h[illegible] alive on 5/10 1930, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Hypertension. Arterio-sclerosis

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Boots, M. D.

5/13 1930 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL May 13 1930

20 UNDERTAKER Rita Wiedefeld

ADDRESS 914 Greenmount Ave

May 13 1930

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57106

E 57106

CERTIFICATE OF DEATH.

REGISTERED NO. 116-301

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caution & Clover ST. 12-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Vicchio

(a) RESIDENCE NO. 2229 Huntington Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Vicchio

6 DATE OF BIRTH (month, day, and year) Feb. - 1873

7 AGE: Years 57 Months 3 Days 8 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Savarlono Vicchio

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Beatrice Capretta

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Mr. John Vicchio (Address) 2229 Huntington Ave

15 Filed 1 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 10, 1930, that I last saw him alive on May 10, 1930, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Right Inguinal Hernia Strangulated

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 8, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) V. Messina M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pall Cathedral | DATE OF BURIAL: May 12, 30

20 UNDERTAKER: A. S. Marshall | ADDRESS: 353 Fallsway

Spec.—2-29-28—L. F. S.—500 Blks.

(Albert Pfister)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57107 ✓ 129 E 57107

E 57107

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH 3165 Leeds St ST. 20-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2—FULL NAME Robert Pfister

(a) RESIDENCE NO. 3165 Leeds St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Pfister

DATE OF BIRTH (month, day, and year) Apr 4-1864

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	1	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 050

(c) Name of employer ✓

BIRTHPLACE (city or town) (State or country) Switzerland

10 NAME OF FATHER Albert Pfister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

Informant Mary Pfister

(Address) 3165 Leeds St

Filed MAY 12 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12-1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 12, 1930, that I last saw him alive on May 12, 1930 and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) ✓ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Ec + Phy Exam

(Signed) J. T. Lyerly, M. D.

, 19 (Address) 3321 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem.

DATE OF BURIAL May 14th 1930.

20 UNDERTAKER Chas. W. Dill

ADDRESS 3109 Fredk Ave.

Spec. 2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57108 ✓ E 57108

CERTIFICATE OF DEATH

123

REGISTERED NO. 24-35

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1443 Reynolds ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine Schmidt

(a) RESIDENCE NO. 1443 Reynolds ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 4½ mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Schmidt

DATE OF BIRTH (month, day, and year) Nov. 28-1881

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	5	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Hungary

10 NAME OF FATHER Philip Muth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Anna Bayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

Informant Joseph Schmidt

(Address) 1443 Reynolds

Filed ....., 19.... By ..... Registrar

C. HAMPSON JONES, M. D.

21930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 9. 1930

17 I HEREBY CERTIFY, That I attended deceased from April. 14, 1930, to May 9, 1930

that I last saw h[illegible] alive on May 9, 1930

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis, Gall Stones and Septicaemia

Three Hundred

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 9-1929

Was there an autopsy? no

What test confirmed diagnosis? Laboratory Urinary Urine

(Signed) Thos A. O. Stevens, M. D.

5/10, 1930 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross, C. G. Co. Md

DATE OF BURIAL May 13 1930

20 UNDERTAKER Chas. L. Stevens

ADDRESS 150 E Pont. Ex.

Spec.—1-30—M. & T.—250 Bks.

E 57109

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57109

CERTIFICATE OF DEATH.

REGISTERED NO. 84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 231 N Chapel St (ST.) (6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franz Loechel

(a) RESIDENCE NO. 231 N Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Loechel

DATE OF BIRTH (month, day, and year) Jan 21 1852

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	3	21	

OCCUPATION OF DECEASED Butcher 013

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) retired 10 years

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Loechel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Von Meyerosky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Pauline Loechel

(Address) 231 N Chapel St

Filed 2 1930, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 14 1929 to May 11 1930,

that I last saw him alive on May 9 1930, 7 45 A M m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Heart Block

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

Bronchitis (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas B Heyman M. D.

5/30, 19 30 (Address) 718 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews Cemetery

DATE OF BURIAL May 13 1930

ADDRESS 2008 Orleans St.

20 UNDERTAKER John Ulrich

Spec.—1-30—M. & T.—250 Blks.

E 57110 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57110

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 22-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Robert Geter

(a) RESIDENCE NO. 213 S. Fremont St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Rose

7 DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	43			

8 OCCUPATION OF DECEASED Laborer

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) N. C.

10 NAME OF FATHER Gillam Geter

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Ann ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

Informant Records of

(Address) Baltimore City Hospitals

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-5-30

17 I HEREBY CERTIFY, That I attended deceased from 4-22-30, 19..., to 5-5-30, 19...,

that I last saw him alive on 5-5-30, 19...,

and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute.

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Hypertension Morethen (duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical, Lab.

(Signed) Paul Padget, M. D.

5-9-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

MAY 12 1930

Per. W. H. Rogers

MAY 12 1930

46516 THE MONOG...

Spec.--8-16-29--L. F. S.--100 Bks.

E 57111 — HEALTH DEPARTMENT—CITY OF BALTIMORE — E 57111

CERTIFICATE OF DEATH

REGISTERED NO. 161-201

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Young

(a) RESIDENCE NO. 617 Lorgel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word): —

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5/3/30

7 AGE: Years | Months | Days 5 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Cookman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

Informant Friend.

(Address) JOHNS HOPKINS HOSPITAL

Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 6 30

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to May 6, 1930, that I last saw her alive on May 6, 1930 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy

(Signed) J. R. Richford, M. D.

5/9, 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL ....., 19....

20 UNDERTAKER — ADDRESS

Commissioner Health

MAY 12 1930

4638

MAY 12 1930

Spec.—1-30—M. & T.—250 Bks.

E 57112 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57112

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 22-30 ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Roche

(a) RESIDENCE NO. 309 Sharpe St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) March 12, 1863

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	67	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

10 NAME OF FATHER James Roche

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mary Brady

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

PARENTS

14 Informant Records of (Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

2 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-9-30

17 I HEREBY CERTIFY, That I attended deceased from 2-12-30, 19..., to 5-9-30, 19...,

that I last saw him alive on 5-9-30, 19...,

and that death occurred, on the date stated above, at 2:45 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) over 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) over 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren W. McLane, M. D.

5-10, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL May 12, 1930

UNDERTAKER John J. Fahey Sons — ADDRESS 1518 Light St.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57113

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57113

CERTIFICATE OF DEATH

100-001

1—PLACE OF DEATH United States Marine Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore, Maryland. ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Franklin

(a) RESIDENCE NO. The Anchorage, Baltimore, Maryland. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 8, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work A. B. Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS West Imboden

9 BIRTHPLACE (city or town) Chicago, Illinois (State or country)

10 NAME OF FATHER John H. Franklin

11 BIRTHPLACE OF FATHER (city or town) not known (State or country)

12 MAIDEN NAME OF MOTHER Alice McLeib

13 BIRTHPLACE OF MOTHER (city or town) not known (State or country)

Informant U. S. Marine Hospital Records.

(Address) Baltimore, Maryland.

Filed , 19 (C. HARRISON JONES, M. D.) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1930.

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to May 9, 1930,

that I last saw him alive on May 9, 1930

and that death occurred, on the date stated above, at 6:45 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory.

(Signed) Ralph E. Porter M. D.

5-10, 1930 (Address) U. S. Marine Hospital, Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys, Hampden	May 14, 1930
20 UNDERTAKER	ADDRESS
E Leroy Stiffler, Inc.	125 E. North Ave.

E 57114

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57114

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Josephs Hospital WARD) 38-6 St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carroll A Dorney (If not over 1 yr., St.; yrs., mos. ds.)

(Residence in Baltimore: No. 4212 Springdale Ave

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	Married

6-DATE OF BIRTH, Sept (Month) 18 (Day), 1891 (Year)

7-AGE, 38 yrs. 7 mos. 22 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Advertising (b) General nature of industry, business, or establishment in which employed (or employer) Salesman

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. J Frank Dorney

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER. Betty B Cadell

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Dorney

(Address) 4212 Springdale Ave

15- Filed ..... 191..... Per ..... Registrar.

C. HAMPSON JONES, M. D.

1930

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5 (Month) 11 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Uremia due which he was Chronic nephritis (C.C.) Duration) ..... yrs. ..... mos. ..... ds. as CONTRIBUTORY (Secondary) Bronchial Pneumonia (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G H Fraunfelter M. D. (Coroner.)

5/13/, 1930 (Address) 2939 W. Eldeg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Baltimore Md

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, 5/12/30 19....

20-UNDERTAKER John F Dahlgren Sons

ADDRESS 1318 Light St

Spec.—1-30—M. & T.—250 Bks

Hosp
729 Wash Blvd

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 57115

E 57115

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Harmon Ave ST., 25-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse L Reed

(a) RESIDENCE NO. 1808 Harmon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Flora R Reed

6 DATE OF BIRTH (month, day, and year) April 7-1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gas Electric Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Christian Herter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Sarah L Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Flora R Reed

(Address) 1808 Harmon Av

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1929, to May 10, 1930, that I last saw h~~im~~ alive on May 8, 1930, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Cardiac Arhtetan

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C Murray Young, M. D.

May 12 1930 (Address) 729 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Park Cemetery

DATE OF BURIAL 5/13 1930

20 UNDERTAKER William Coale

ADDRESS 1217 St Paul

MAY 13 1930 C. H. D. BALTIMORE, MD.

Spec.—1-30—M. & T.—250 Bks

E 57116

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 57116

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1649 N. Fulton Ave WARD 25-21)

2-FULL NAME John Thomas Lloyd

(a) RESIDENCE NO. 1649 N. Fulton Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

6 If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Sophie E. Lloyd

7 DATE OF BIRTH (month, day, and year) Dec 15-1855

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
74		4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of Industry, business, or establishment in which employed (or employer) Mfg

(c) Name of employer American Can Co

9 BIRTHPLACE (city or town) Balto. (State or country) Md

10 NAME OF FATHER Reuben Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Susan Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

Informant (Address) Mrs Sophie Lloyd 1649 N. Fulton Ave

Filed 1-3 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10/1930

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to May 10, 1930, that I last saw him alive on May 10, 1930, and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis Clinical Evidence

(Signed) G. W. Finkelstein, M. D.

, 19 (Address) 827. W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 5/12/ 19 30

20 UNDERTAKER Wm Cook 1217 St

ADDRESS Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57117 ✓ E 57117

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 215 S. Sharp St. St. 22-30 Ward)

2-FULL NAME Charles R. Greenwaldt. (Zalegiris)

(a) RESIDENCE NO. 215 S. Sharp St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 9 mos. 0 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Catherine Greenwaldt

6 DATE OF BIRTH (month, day, and year) August 9, 1888

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	41	9	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Auto mechanic
(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore City
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas R. Greenwalt (Zalegiris)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania.

12 MAIDEN NAME OF MOTHER Jennie Mazer.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Catherine Greenwaldt (Zalegiris)
(Address) 215 S. Sharp St.

15 Filed MAY 13 1930 Signature H. HANSON JOHNS, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) May 9, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry & Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry & Autopsy (Inquest, autopsy or inquiry) deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What tests confirmed diagnosis? Autopsy & Inquiry

(Signed) Ethel Eminhardt, M. D.

5/12, 1930 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Funeral Home

DATE OF BURIAL 5/13/1930

20 UNDERTAKER [illegible] Park 1217 Eutaw St

ADDRESS

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57118

CERTIFICATE OF DEATH.

E 57118

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1007 Dr Soto Rd ST. 25-72 WARD

2-FULL NAME Frederick W. Becker

(a) RESIDENCE. No. 1007 # Dr Soto Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine L Becker

6 DATE OF BIRTH (month, day, and year): Jan 18th 1848

7 AGE — Years: 82 Months: 3 Days: 23. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: William L Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catherine Becker
(Address): 1007 De Soto Road

Filed MAY 13 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 9th, 19 , to , 19 , that I last saw him alive on May 9th, 1930, and that death occurred, on the date stated above, at 1230 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) B. Kadin, M. D.

, 19 (Address) 2306 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western — DATE OF BURIAL: May 13 1930

20 UNDERTAKER: E. Ohlemann & Son — ADDRESS: 1039 Hanover

Spec.—1-10-21—M&T—1500 Bks.

57119

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 57119

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST 26-41 WARD)

2-FULL NAME Cora Grumpmach

(a) RESIDENCE NO. 4202 Woodlea Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Grumpmach

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 58 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER James Hagen

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C

12 MAIDEN NAME OF MOTHER Clarent Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant George A. Grumpmach (Address) 4202 Woodlea Ave

15 Filed MAY 13 1930 HARRISON JONES, M. D. Registrar

By ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-11-30

17 I HEREBY CERTIFY, That I attended deceased from 5-4, 1930, to 5-11, 1930, that I last saw her alive on 5-10, 1930 and that death occurred, on the date stated above, at 7.50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypertension

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia & Cardiac failure (duration) yrs. mos. 10 ds.

Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) M Blumberg, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem.

DATE OF BURIAL: May 14 1930

20 UNDERTAKER: Thomas Flynn

ADDRESS: 361 [illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57120

CERTIFICATE OF DEATH.

135 E 57120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline ST. E 12-51 WARD)

2-FULL NAME Jefferson Hoffman

(a) RESIDENCE NO. 2113 Huntington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude V. Hoffman

6 DATE OF BIRTH (month, day, and year) Feb 26 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work P P Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Y.M.C.A.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Gertrude V. Hoffman (Address) 2113 Huntington Ave

15 Filed ..., 19... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-11 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-18, 1930, to 5-11, 1930, that I last saw him alive on 5-11, 1930, and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of Prostate

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 3-25-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) W B Townsend, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL May 14 1930

20 UNDERTAKER Thos. Wilson Sons

ADDRESS 1015 E Baltimore

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57121

E 57121

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 766 Sarah Ann St. 4-26 Ward)

2-FULL NAME Carrie Scott

(a) RESIDENCE NO. 766 Sarah Ann St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Negro	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Jeff. Scott

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. T. Robinson
(Address) 766 Sarah Ann St.

15 Filed MAY 13 1930 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) August Tilley, M. D.

5/9. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL May 13 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St

Spec.—1-10-21—M&T—1500 Bks.

57122

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57122

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp. W. 47-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Filghman

(a) RESIDENCE NO. 513 W. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1902

7 AGE: Years 28 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Chas. Filghman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Fannie Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Louisa Filghman

(Address): 513 W. Biddle St.

15 Filed 3-1930 G. HALSEY JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-10 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-8, 1930, to 5-10, 1930, that I last saw h alive on 5-10, 1930, and that death occurred, on the date stated above, at 7 PM m.

The CAUSE OF DEATH* was as follows:

Tuberculous pneumonia

(duration) yrs. mos. 36 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical - X Ray

(Signed) W B Hendrix M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: May 14, 1930

20 UNDERTAKER: Jesse W. Redden — ADDRESS 1426 W. Biddle

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57123 | REGISTERED NO. 13-54 | 117 | E 57123

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Alhambra Cpt. ST. 2a. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fredericka Gundersheimer

(a) RESIDENCE NO. Alhambra Cpt. 2a. WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Potomac How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan Gundersheimer

DATE OF BIRTH (month, day, and year) Oct. 15, 1866

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Joseph Leopold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Weiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mr. H. Gundersheimer

(Address) Park Ave.

Filed MAY 13 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 11, 1930, that I last saw h[illegible] alive on May 11, 1930, and that death occurred, on the date stated above, at [illegible] p. m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Wolman, M. D.

May 12 1930 (Address) 2444 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ahabath Shalom Cem.

DATE OF BURIAL 5/13/1930

ADDRESS 115 W. Mt. Royal Ave

20 UNDERTAKER David Sondheim

Spec.—1-30—M. & T.—250 Bks.

57124

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 57124

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1040 University St., Stony WARD)

2-FULL NAME Edwin Bruce Dowell

(a) RESIDENCE NO. 1040 W. University St. Stony WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Barton Dowell

7 DATE OF BIRTH (month, day, and year) Aug. 15 1848

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) Lunch Room

(c) Name of employer Retired 10 yrs.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Benj. Dowell

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Adeline Marshall

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

Informant Mrs. Harry R. Ruse

(Address) 402 Somerset Rd.

Filed MAY 13 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct- ....., 1929, to May-11- 1930, that I last saw h.. alive on May 10- ....., 1930, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer malignancy suspected. Arteriosclerosis Senility

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Angina Fractures Coronary Sclerosis (duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Was made by Autopsy Physical examination

(Signed) ..... M. D.

, 19 (Address) 280 E. Raby Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL May 1930

20 UNDERTAKER Wm. Tickner & Sons

ADDRESS North & Pa

Spec.—1-30—M. & T.—250 Bks.

Hooton

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 57125

CERTIFICATE OF DEATH.

E 57125

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 N. Caroline St., 9-17 WARD)

2-FULL NAME Annie Elizabeth Hooton

(a) RESIDENCE NO. 1710 N. Caroline ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town, where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Samuel T. Hooton

7 DATE OF BIRTH (month, day, and year) Sept 27-1842

AGE: Years 87 | Months 7 | Days 14 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Wheeling (State or country) W. Va

10 NAME OF FATHER Geo. Sawtell

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Eliza Devol

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

Informant Mrs. E. T. Hooton

(Address) 3200 Elgin Ave.

Filed ..... 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11-1930

17 I HEREBY CERTIFY, That I attended deceased from May 3 1930, to May 10 1930, that I last saw h[illegible] alive on May 9 1930, and that death occurred, on the date stated above, at 6:30 a.m. Instant

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) ..... yrs. ..... mos 7 ..... ds.

CONTRIBUTORY (Secondary) Senile Decay

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. H. Mortimer, M. D.

5/12, 1930 (Address) 3320 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL May 13 1930

ADDRESS

UNDERTAKER Wm. J. Tickner & Sons

ADDRESS N. Y. Pa

1930 C. HAMILTON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57126

E 57126

CERTIFICATE OF DEATH.

24

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 26-3 WARD)

2-FULL NAME Kenneth Jacoby

(a) RESIDENCE NO. 508 S. Rehugh ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Feb 7- 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at School

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

10 NAME OF FATHER Edward A Jacoby

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Emma M

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Baltimore Md.

14 Informant Edward A. Jacoby

(Address) 508 S. Rehugh St

C. HARRISON JONES, M. D.

Filed MAY 13 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/12/30

17 I HEREBY CERTIFY, That I attended deceased from 5-7, 1930, to 5/12, 1930, that I last saw him alive on 5/12, 1930, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Meningococcus Meningitis

(duration) ..... yrs. ..... mos 11 ds.

CONTRIBUTORY (Secondary) none

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Culture + smear

(Signed) J. E. Goodman, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery

DATE OF BURIAL May 13 1930

20 UNDERTAKER George W Zickler

ADDRESS 1737 E. Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57127

E 57127

REGISTERED NO.

1—PLACE OF DEATH
CITY OF BALTIMORE: (No.) Franklin Sq. Hosp. ST. (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daisy Erdman
(a) RESIDENCE NO. 4813 Forest Park ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Married

6a If married, widowed, or ~~HUSBAND of~~ (or) WIFE of Maurice C. Erdman

7 DATE OF BIRTH (month, day, and year) Sept. 20 1885

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44 yrs	7	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER John Mullen

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Cannon

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Husband
(Address) 4813 Forest Park ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1930

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1930, to May 10, 1930, that I last saw her alive on May 10, 1930, and that death occurred, on the date stated above, at 10:45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast with metastasis to liver and spleen (duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?
Did an operation precede death? Yes Date of Biopsy of tumor of breast March 19 1930
Was there an autopsy? Yes
What test confirmed diagnosis? autopsy
(Signed) Arthur Rathemi, M. D.
5/12 1930 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge — DATE OF BURIAL 5/13 1930

20 UNDERTAKER Liston P. Fussell & Co. — ADDRESS 2620 St Paul

JAMES C. HAMILTON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 57128 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57128

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 18-76 ST. ..... WARD)

REGISTERED NO. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Duffin (Smith?)

(a) RESIDENCE NO. 17 N. Amity St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

7 DATE OF BIRTH (month, day, and year) Unknown

8 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
29?	49?			

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Robert Duffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10-30

17 I HEREBY CERTIFY, That I attended deceased from 5-4-30, 19..., to 5-10-30, 19...,

that I last saw h.. alive on 5-10-30, 19...,

and that death occurred, on the date stated above, at 7:20 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum, rt.

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marion W. McLean M. D.

5-10, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon

DATE OF BURIAL May 13th 19

20 UNDERTAKER A. Jones

ADDRESS 1115 Edmon

MAY 13 1930 E. HAROLD JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57129

CERTIFICATE OF DEATH

34 ✓ E 57129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Ashland Ave ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Ambrose Truitt

(a) RESIDENCE NO. 1502 Ashland Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 4 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col.	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Truitt

6 DATE OF BIRTH (month, day, and year) Dec. 19, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Robert Truitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Eliza

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Martha Truitt

(Address) 1502 Ashland Ave.

15 Filed C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1930, to May 10, 1930, that I last saw him alive on May 9, 1930 and that death occurred, on the date stated above, at 8 30 p m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Tuberculosis of L. plevra

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical, X ray

(Signed) H Macco Williams, M. D.

5-11, 1930 (Address) 1830 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL May 14 1930

20 UNDERTAKER Edward Bryan — ADDRESS 631 Orleans St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57130 90 E 57130

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1747 E. Federal St St. 8-17 Ward)

2-FULL NAME John Sterkel

(a) RESIDENCE NO. 1747 E. Federal St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Sterkel (nee Owens)

6 DATE OF BIRTH (month, day, and year) Oct 17/1860

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	69	6	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Insurance Broker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Sterkel & Elliott

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Peter Sterkel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie E. Sterkel
(Address) 1747 E. Federal St

15 Filed MAY 13 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Chr Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

5/12/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dem Moore

DATE OF BURIAL 5/14/1930

20 UNDERTAKER Gr. Weber & Son

ADDRESS 53 Edmondson

Spec.—1-30—M. & T.—250 Bks.

E 57131

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57131

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 13-57 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hoffman

(a) RESIDENCE NO. 1506 W. 36th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Jennie

6 DATE OF BIRTH (month, day, and year) April 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	50	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia (State or country)

10 NAME OF FATHER Isaac Hoffman

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

Informant Mrs Jennie Hoffman

(Address) 1506 W. 36th St.

Filed 1930 19 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/12/30

17 I HEREBY CERTIFY, That I attended deceased from 4/28/30, 19..., to 5/12/30, 19...,

that I last saw h[illegible] alive on 5/12/30, 19...,

and that death occurred, on the date stated above, at 4:35 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 5/7/30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) David Jenner M. D.

5/12/30 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Workman Circle Lmet

DATE OF BURIAL 5/13, 19 30

20 UNDERTAKER Goldwinson & Bro

ADDRESS 1127 E Balto st

Spec.—8-16-29—L. F. S.—100 Blks.

E 57132

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57132

CERTIFICATE OF DEATH

REGISTERED NO. 25-3

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2228 Sidney Ave. WARD 25)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Henry Biden

(a) RESIDENCE NO. 2228 Sidney Ave ST. 25 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

6 If married, widowed or divorced HUSBAND of (or WIFE of) Sarah J. C. Biden

7 DATE OF BIRTH (month, day, and year) unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Track Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer W. Dist. C. R. R.

BIRTHPLACE (city or town) (State or country) Balto Co.

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

Informant Mrs Chas H Biden

(Address) 2228 Sidney Ave

Filed MAY 15 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1929, to May 12, 1930

that I last saw h[illegible] alive on May 11, 1930

and that death occurred, on the date stated above, at 3 00 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of April 2, 1930

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H. Hammond Wheeler M. D.

5/12, 1930 Address) 2410 Hollins Ferry Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 5/14 1930

20 UNDERTAKER C. D. Fanning Son

ADDRESS 1936 Lafayette ave.

Spec—12-23-21—E.B.R.S.—400 Blks.

E 57133

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001

E 57133

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2334 Aiken St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Agnes Gertrude Newkirk

(a) Residence No. 2334 Aiken St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or ~~divorced~~, HUSBAND of (or) WIFE of George Newkirk

6-DATE OF BIRTH (month, day and year) Jan. 19-1873

7-AGE, 57 yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Chesapeake City Md.

PARENTS.

10-NAME OF FATHER. Peter Thomas Chandler

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Chesapeake City Md.

12-MAIDEN NAME OF MOTHER. Emily Hayes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Mrs. Florence Walter

(Address) Chesapeake City Md.

15- Died [illegible] 1930 [illegible] Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 14 1930

17- I HEREBY CERTIFY, That I attended deceased from May 9 1930, to May 11 1930, that I last saw h[illegible] alive on May 11 1930, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Symptoms

(Signed) Albert L. Ringswald, M. D.

5/22, 1930 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Olivet Cem. DATE OF BURIAL. May 14 1930

20-UNDERTAKER. Wm. N. Valentine ADDRESS 2326 Aiken St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57134

E 57134

CERTIFICATE OF DEATH

REGISTERED NO. 13-59 90

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. 2547 Madison ST., WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Janie Parker

(a) RESIDENCE NO. 2547 Madison ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: F. | 4 COLOR OR RACE: Col. | 5 Single, Married, Widowed, or Divorced, (write the word): M

If married, widowed, or divorced (or) WIFE of: Herbert Parker

DATE OF BIRTH (month, day, and year)

AGE: Years 55 | Months 1 | Days 16 | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Ind

BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: Jerry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Louisa Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Herbert Parker
(Address): 2547 Madison Ave

Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar
MAY 29 1930 By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/11/30

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1930, to May 11, 1930

that I last saw her alive on May 11, 1930

and that death occurred, on the date stated above at 3:45 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis & Insufficiency
(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. J. Hatcher, M. D.
5/13 1930 (Address) 1111 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon C. A. Co. | DATE OF BURIAL: May 14 1930

20 UNDERTAKER: Wm. H. Chase & Son | ADDRESS: 1400 Mosher

Spec.—1-30—M. & T.—250 Bks.

E 57135

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57135

CERTIFICATE OF DEATH.

87

1-PLACE OF DEATH Baltimore City Hospitals (T. B.) 15-21 REGISTERED NO.

CITY OF BALTIMORE: (No. ..... St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Butler

(a) RESIDENCE NO. 1422 Vincent st. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	COL.	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1887

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Jane ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hospital Records

(Address) .....

5-12-30 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1930, to May 10, 1930, that I last saw her alive on May 10, 1930, and that death occurred, on the date stated above, at 11.10 p. m.

The CAUSE OF DEATH* was as follows:

Fibrinous pericarditis

(duration) Unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas. Stevenson M.D.

(Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL M. Sulzer

DATE OF BURIAL 5-13 1930

UNDERTAKER Sam'l H. Chase Son

ADDRESS 1402 Mosher

5-13 1930 Per .....

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57136

E 57136

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 4-7 WARD)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Thielbahr

(a) RESIDENCE NO. 160 N. Gay st. (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1870

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 940

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER John Thielbahr

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Thielbahr

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Germany

Informant Hospital Records

(Address) UNIVERSITY OF MARYLAND

Filed ....., 19 C. HAMPSON JONES Registrar

4:40 P.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1927, to May 8, 1930,

that I last saw him alive on May 8, 1930,

and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Pul. tuberculosis -

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What tests confirmed diagnosis? Clinical

(Signed) Jas. Stanard Jr. M. D.

5-9, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cremated May 9 and Interred Loudon Park

DATE OF BURIAL 5/17 1930

20 UNDERTAKER by Joseph O. Cook

Undertaker Hadel 1005 W. Baltimore St.

ADDRESS

MAY 1 1930

Spec.—1-30—M. & T.—250 Blks.

E 57137 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57137

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 26-37 REGISTERED NO. 49

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George V. Kleinfelter

(a) RESIDENCE NO. ? ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1845

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84?			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) La.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records of (Address) Balto. City Hospitals

Filed 5-31-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-8-30

17 I HEREBY CERTIFY, That I attended deceased from 2-2-22, 19..., to 5-8-30, 19...,

that I last saw him alive on 5-8-30, 19...,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) over 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

(duration) over 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home of Care

Did an operation precede death? Yes Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin W. McCrea, M. D.

5-10, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Univ. of Md. UNIVERSITY OF MARYLAND

20 UNDERTAKER Commissioner Health.

DATE OF BURIAL MAY 13 1930 19

ADDRESS

Mrs. Catherine A. Neal.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57138

CERTIFICATE OF DEATH

182 E 57138

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Town Harbor. St. 3-4 Ward)

2-FULL NAME Frank Rostkowski

(a) RESIDENCE NO. 720 S Dallas St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	W.	Sngle

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 19 - 1910

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	20		13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Labor
(c) Name of employer City

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER Alexander Rostk

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Zacanowski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant
(Address) 720 S Dallas St

15 Filed ... 19... HAMPSON JONES, M. D. (Registrar)

8 1930 — Case Federal Aid Poultry investigation Hoadley

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry. (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc Drowning

(duration) ... yrs. ... mos. — ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) ... yrs. ... mos. — ds.

18 Where was disease contracted if not at place of death? Foot foot Basin

Did operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ... M. D.

May 3 1930 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	May 13 1930
20 UNDERTAKER	ADDRESS
John M Weber & Co	Chester St

Spec. 7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

37-802 ✓

E 57139

CERTIFICATE OF DEATH

E 57139

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 138 So. London Ave St. 10-71 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Bessie E. Ward

(a) RESIDENCE NO. 138 So London Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widnwed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Oct 3. 1874

7 AGE: Years 55 Months 7. Days 10

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which emplnyed (or employer): ✓

(c) Name nf emplnyer: North Bros.

9 BIRTHPLACE (city or town) (State or country): Calvert County Md.

PARENTS

10 NAME OF FATHER: Robert E. Ward.

11 BIRTHPLACE OF FATHER (City or tnwn) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Velonia Stallings

13 BIRTHPLACE OF MOTHER (city nr tnwn) (State or country): Anne Arundel Co. Md

14 Informant: Herbert E Stallings (Address) 138 London Ave.

15 Filed 3 1930 C. HAMPSON JONES, M. D. Registrar Per RRH.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (mnnth, day, and year) 19: May 13-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1929, to May 13, 1930, that I last saw her alive on May 11, 1930, and that death occurred, on the date stated above, at 11.30 m. ante meridian.

The CAUSE OF DEATH* was as follnws:

Tuberculosis (General)

(duration) ✓ yrs. 6 mos. ✓ ds.

CONTRIBUTORY (Secondary) Myocarditis

(duratinn) ✓ yrs. ✓ mos. 3 wks

18 Where was disease contracted if not at place of death? ✓

Did an nperation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) George L. Shannon, M. D.

(Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

Date of Burial: May 15 1930

20 UNDERTAKER: Margaret A. Flynn

ADDRESS: 1422 Light St.

Spec.—1-10-21—M&T—1500 Bks.

(Overwetter)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57140

CERTIFICATE OF DEATH.

REGISTERED NO. 57140

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 10-72 (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Overwetter
(a) RESIDENCE NO. 2653 Wilkins Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 2 yrs. 4 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dec 17-1927
6 DATE OF BIRTH (month, day, and year)
7 AGE: Years 2 Months 6 Days 28 If LESS than 1 day, hrs. or min. 4
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS
10 NAME OF FATHER: John Overwetter
11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md
12 MAIDEN NAME OF MOTHER: Augusta Sanbeck
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Reno Nev

14 Informant: John Overwetter
(Address): 631 Pulaski St.

15 Filed 3 1930 19
C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 14th, 1930, to May 12, 1930, that I last saw him alive on May 12, 1930, and that death occurred, on the date stated above, at 10:10 A m.

The CAUSE OF DEATH* was as follows:
Myocarditis
Endocarditis

CONTRIBUTORY (Secondary) Lobar pneumonia, Empyema, (duration) yrs. 1 mos. 5 ds.

18 Where was disease contracted if not at place of death? at Home
Did an operation precede death? Yes Date of May 3 1930
Was there an autopsy? No
What test confirmed diagnosis? Physical findings, Operation
(Signed) Nicholas L. Zonelli M. D.
, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Cemetery
DATE OF BURIAL: May 14th 1930
UNDERTAKER: J. B. Wagner
ADDRESS: 1150 W. Baltimore St

Spec.—1-30—M. & T.—250 Bks

John Lewis Glacken ✓

E 57141 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57141

CERTIFICATE OF DEATH.

× 31

REGISTERED NO. 12-49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hosp. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lewis Glacken

(a) RESIDENCE NO. Reisterstown, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 7 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Balt. Co. (State or country) Md.

10 NAME OF FATHER George Glacken

11 BIRTHPLACE OF FATHER (city or town) — (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Eva Sprinkle

13 BIRTHPLACE OF MOTHER (city or town) Balt. Co. (State or country) Md.

Informant Mrs. Geo. Glacken

(Address) Reisterstown, Md.

Filed MAY 13 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 19 30 to May 13, 19 30,

that I last saw h alive on May 13, 19 30,

and that death occurred, on the date stated above, at 10 56 a.m. (Daylight)

The CAUSE OF DEATH* was as follows:

Pneumonia, bilateral,

(probable tuberculous pneumonia)

(duration) yrs. 5? mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (Reisterstown, Md.)

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) [illegible], M. D.

May 13, 1930 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dover Cemetery Balto Co Md

DATE OF BURIAL May 15 1930

20 UNDERTAKER J. F. Cline & Son

ADDRESS Reisterstown Md

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57142

CERTIFICATE OF DEATH

168 E 57142

REGISTERED NO. 15-63

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4415 Garrison Boulevard St., Ward)

2-FULL NAME MARY JOSEPHINE TEXTOR

(a) RESIDENCE NO. 4415 Garrison Blvd. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. Textor

6 DATE OF BIRTH (month, day, and year) April 10, 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	75	1	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) West Virginia

PARENTS

10 NAME OF FATHER Thomas McGuire

11 BIRTHPLACE OF FATHER (city or town)
(State or country) West Virginia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant Mrs. Elizabeth Nichlaus
(Address) 103 E. 33rd St. (Sister-in-Law)

15 Filed May 13 1930 G. HAMPSON JONES, M. D. Registrar
per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide

Strangulation by Hanging

(duration) yrs. Instantaneous

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 4415 Garrison Blvd.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regulation

(Signed) F. C. Guth M. D.

(Address) May 12th 1930 Coroner

*State the Itisease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laudon Park Cem.

DATE OF BURIAL May 14 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore & Broadway

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57143

90 E 57143

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1433 Laurens ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles T. Schneider

(a) RESIDENCE NO. 1433 Laurens ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Albertina Schneider

DATE OF BIRTH (month, day, and year) March 04-1854

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	1	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Charles Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Hannah Schneider

(Address) 1433 Laurens St

C. HAMPSON JONES, M

Filed 3 1930 19 Par R.C.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12-1930

17 I HEREBY CERTIFY, That I attended deceased from May 1 19 30 to May 12 19 30

that I last saw h— alive on May 7 19 30

and that death occurred, on the date stated above, at 10 30 p. m.

THE CAUSE OF DEATH* was as follows: Chronic Endocarditis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Debility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Stout M. D.

(Address) 1307 W Mount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL May 15 1930

UNDERTAKER Harry W. Ehlen

ADDRESS 1414 N. Gilmor

Spec.—8-16-29—L. F. S.—100 Bks.

E 57144

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57144

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4-310 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Jones

(a) RESIDENCE NO. Fallston, Harford Co ST., Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Jones

7 DATE OF BIRTH (month, day, and year) Dec 12 1859

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Geo W. Jones

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Mary E Carey

13 BIRTHPLACE OF MOTHER (city or town) Harford Co (State or country)

Informant Howard Thorpe

(Address) Fallston Md

FILED 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 6 1930, to May 13 1930, that I last saw him alive on May 13 1930 and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows: Carcinoma of stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) W. H. Varney M. D.

1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Goodwill Cem Harford Co

DATE OF BURIAL May 15 1930

20 UNDERTAKER P. E. Gilbert & Son ADDRESS Jarrettsville Md.

Spec.—1-30—M. & T.—250 Bks

E 57145 HEALTH DEPARTMENT—CITY OF BALTIMORE

100 E 57145

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital (STREET) 1951 ..... WARD .....

2-FULL NAME John Allen Carter

(a) RESIDENCE NO. 2949 Bernard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Ford

7 DATE OF BIRTH (month, day, and year) Dec 3 1888

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
41		5	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER David Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Lillian Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

Informant John A. Carter
(Address) 2949 Bernard

Filed MAY 4 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1930

17 I HEREBY CERTIFY That I attended deceased from April 21, 1930, to May 13, 1930, that I last saw him alive on May 13, 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Lung abscess

(duration) ....yrs. ....mos 20 da.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & autopsy

(Signed) Nicholas Sumpson M. D.

, 19 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

UNDERTAKER Chenoweth Lee

DATE OF BURIAL May 15 19 30

ADDRESS 3615 Eldrid

Spec.—8-16-29—L. F. S.—100 Bks.

E 57146

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 57146

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3416 Keswick Rd ST. 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Hood

(a) RESIDENCE NO. 3416 Keswick Rd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	widowed.

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Lula Hood.

DATE OF BIRTH (month, day, and year) April 21-1861

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	0	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster. 0-45

(b) General nature of industry, business, or establishment in which employed (or employer) Produce

(c) Name of employer Self.

BIRTHPLACE (city or town) Ocella

(State or country) Maryland.

10 NAME OF FATHER Alfred Hood.

11 BIRTHPLACE OF FATHER (city or town) Ocella

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Laura Webb

13 BIRTHPLACE OF MOTHER (city or town) Ellicott City

(State or country) Maryland.

Informant Albert Hood.

(Address) 3206 Keswick Rd.

Filed MAY 14 1930, 19 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12-1930.

17 I HEREBY CERTIFY, That I attended deceased from May 1- 19 19, to May 12- 19 30; that I last saw h[illegible] alive on May 11- 19 30 and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs & urinalysis

(Signed) Chester Kulund, M. D.

5-12-1930 (Address) 2522 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Hampden	May 15 1930
20 UNDERTAKER	ADDRESS
Chenowith Son	3615 Elmtree ave

Spec.—1-12-23—M&T—500 Blks.

E 57147 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57147

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 N. Mount ST. 16-27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Cole

(a) RESIDENCE NO. 621 N. Mount ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored.

5 Single, Married, Widowed, or Divorced. (write the word): married.

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of: Earnest Cole.

6 DATE OF BIRTH (month, day, and year): March 12/98

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
32	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Westernport Md Co Va

10 NAME OF FATHER: Barnes Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Manzie Hatch Carey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

PARENTS

14 Informant: Mary Binns

(Address): 1614 Edmonson ave

15 Filed ..... 19..... Registrar .....

C. HAMILTON JONES, M. D.

MAY 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-11- 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-2-, 1930, to 5-11-, 1930, that I last saw her alive on 5-10-, 1930 and that death occurred, on the date stated above, at 7 A m

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary): Fatty overgrowth of heart unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. H. Hearings, M. D.

5-13-1930 (Address) 611 N. Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: 5/14 1930

20 UNDERTAKER: Thomas. G. Kelson

ADDRESS: 1303 Pennsylvania ave

Spec.—1-12-23—M&T—500 Bks.

E 57148

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 57148

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1606 Lorman St. ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. Neal

(a) RESIDENCE NO. 1606 Lorman St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maud Franklin Neal

6 DATE OF BIRTH (month, day, and year): July 22, 1885

7 AGE — Years: 44 Months: 9 Days: 19 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ann Arundle Co, Md

12 MAIDEN NAME OF MOTHER: Margaret Simms

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ann Arundle Co. Md.

14 Informant: Wm. Neal

(Address) 142 N. Mount St

15 Filed 4-1936 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-11- 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-30- , 1930, to 5-11- , 1930, that I last saw h— alive on 5-11- , 1930, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows: Tuberculosis (Pulmonary).

History

PRIMARY (duration) yrs. 3 mos 12 ds.

Personal knowledge

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) George C. Page, M. D.

, 19 (Address) 1806 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: 5/15 1930

20 UNDERTAKER: Thomas E. Kelson

ADDRESS: 1803 Eastman St

Spec.—1-30—M. & T.—250 Blks.

57149 — HEALTH DEPARTMENT—CITY OF BALTIMORE — VE 57149

14-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 15-23 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Eva Harriet Young

(a) RESIDENCE NO. 1355 N. Calhoun ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of: -

DATE OF BIRTH (month, day, and year): Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44 ?			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress 19 009

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Ellen ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

Informant: Records of

(Address): Balto. City Hospitals

Filed ....., 19 ..... HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-10-30

17 I HEREBY CERTIFY, That I attended deceased from 5-9-30, 19....., to 5-10-30, 19.....,

that I last saw h.er alive on 5-10-30, 19.....,

and that death occurred, on the date stated above, at 9:40 P. m.

The CAUSE OF DEATH* was as follows:

1 Hemorrhage into Cerebrum

(duration) ....yrs. mos 2? da.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLaud, M. D.

5-12, 1930 (Address) Balto. City Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: 5/15 1930

20 UNDERTAKER: Thomas E. Kelson

ADDRESS: 1303 Pierstman St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57150

CERTIFICATE OF DEATH.

57

E 57150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2316 Edmondson Ave ST.) 16-69 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lida H. Davis

(a) RESIDENCE NO. 2316 Edmondson Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Wallace G Davis

6 DATE OF BIRTH (month, day, and year): 11. 29. 1875

7 AGE: Years 54 Months 5 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Harford Co Md

PARENTS

10 NAME OF FATHER: Jas. W. Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co. Md

12 MAIDEN NAME OF MOTHER: Susie Grimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Co Md

14 Informant: Albert H. Wood
(Address): Havre de Grace Md

15 Filed MAY 14 1930 19 C. HARRISON JONES, M. Registrar

By: .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5. 13. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2 1927, to May 13 1930, that I last saw her alive on May 13 1930, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus – Coma
Heart exhaustion

(duration) 3 yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Ed H. Beeton M. D.

5. 13. 1930 (Address) 710 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: May 15 1930

20 UNDERTAKER: David Davidene — ADDRESS: Upper Falls

Spec.—2-29-28—L. F. S.—500 Bks.

E 57151

HEALTH DEPARTMENT—CITY

E 57151

CERTIFICATE OF DEAT

REGISTERED NO. 6-10

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 E Fayette ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Emma Woodruff

(a) RESIDENCE NO. 2204 E Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
female	white	Widow

6 If married, widowed, or divorced (or) WIFE of Marcellus Woodruff

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Edward Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Edna Foster

(Address) 2209 E Fayette

C. HAMPSON JONES, M. D. Registrar

FILED MAY 4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13-1930

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to May 13, 1930

that I last saw her alive on May 13, 1930

and that death occurred, on the date stated above, at 8 20 A.M. E.S

The CAUSE OF DEATH* was as follows:

Carcinoma Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Oedema

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Microscopic findings

(Signed) Edward H. Hood, M. D.

5/15/1930 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emporia Va.	May 15 1930
20 UNDERTAKER Henry Lutz	ADDRESS 1203 Broadway

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57152

CERTIFICATE OF DEATH.

90 ✓

E 57152

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 N. Mount St. ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Oliver

(a) RESIDENCE NO. 111 N. Mount St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Negro	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Oliver

6 DATE OF BIRTH (month, day, and year) Oct. 8th. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	59	7	2	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) House-work

(c) Name of employer Unemployed

9 BIRTHPLACE (city or town) Harristown, Md.

(State or country) Baltimore Co.

10 NAME OF FATHER James Harris

11 BIRTHPLACE OF FATHER (city or town) Harristown, Md.

(State or country)

12 MAIDEN NAME OF MOTHER Arminta Edwards

13 BIRTHPLACE OF MOTHER (city or town) Harristown, Md.

(State or country)

14 Informant Howard R. Harris (Bro.)

(Address) 304 N. Carey st.

Filed 4 1930 19 C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 10th. 1930

17 I HEREBY CERTIFY, That I attended deceased from May, 5th. 1930 to May 10th. 1930

that I last saw her alive on May 9th. 1930

and that death occurred, on the date stated above, at 8.30p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

xMitralxxInsxx

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) About Mitral Ins.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1630 W. Franklin st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harristown, Md

DATE OF BURIAL May 14, 1930

20 UNDERTAKER Mrs. Kate R. Williams

ADDRESS 3224 Schroeder St

Spec.—1-30—M. & T.—250 Blks

No 7882

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57153 ✓ E 57153

90

E 57153

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Bennett Pl. St. 16-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsey Williams

(a) RESIDENCE NO. 906 Bennett Pl ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	col.	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) July 12 1915

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	14.	10		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Edward Williams

11 BIRTHPLACE OF FATHER (city or town) Port. (State or country) Antonio Jamaica B.W.I.

12 MAIDEN NAME OF MOTHER Lessie Allison

13 BIRTHPLACE OF MOTHER (city or town) Balt (State or country) Md.

Informant Lessie Williams

(Address) 906 Bennett Pl.

Filed 1-4 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 12 1930, that I last saw h[illegible] alive on May 11 1930, and that death occurred, on the date stated above, at 4.10 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency 10 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary insufficiency Cardiac (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Patients home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. Warfield Deale M. D.

5/15 1930 (Address) 636 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL May 15, 1930

ADDRESS 3221 Schroeder St

20 UNDERTAKER Mrs Kate R. Williams

Spec.—1-30—M. & T.—250 Bks.

E 57154

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57154

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 27-56 (WARD)

2-FULL NAME Irsie Bragen

(a) RESIDENCE NO. 4845 Pk. Hgts. Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced HUSBAND of or) WIFE of: Joseph Bragen

7 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Louis Kapushna

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Fagis —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

Informant: J. Leurs

(Address) 1739 E Balto

Filed: 1-4 1930 C. HAMILTON JONES, M. D. Registrar

By: Ellis

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): may 13, 1930.

17 I HEREBY CERTIFY, That I attended deceased from april 30, 1930, to may 13, 1930, that I last saw h.e.r. alive on may 13, 1930, and that death occurred, on the date stated above, at 5.10 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary): Emphysema

unk (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) J. H. Conn, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rossdale

DATE OF BURIAL: 5-14 1930

20 UNDERTAKER: Jack Leurs, 1739 E Balto St

ADDRESS

Spec.—2-29-28—L. F. S.—500 Dks.

E 57155

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 57155

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2712 O'Donnell St. ST., 12 WARD)

2—FULL NAME Sister Desideria (Catherine Kuszajewska)

(a) RESIDENCE NO. 2712 O'Donnell St ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Nov. 18, 1896

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	5	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Parochial school teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer St. Casimir's parish

BIRTHPLACE (city or town) Buffalo
(State or country) New York

10 NAME OF FATHER Mathew Kuszajewski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Stawiak

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

Informant Sister superior at St. Cas
(Address) Convent, 2712 O'Donnell St

Filed 4 1930. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1926, to May 12, 1930,

that I last saw her alive on May 12, 1930

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas, M. D.

5-13-30 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cemetary

DATE OF BURIAL: May 15, 1930

20 UNDERTAKER: Stephen J. Fialkowski, INC.

ADDRESS: 1000 S. Kenwood Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 E 57156

E 57156

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 605 Smith St. 14-20 Ward)

2-FULL NAME Richard Wm Smith

(a) RESIDENCE NO. 605 Smith St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Smith

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Owned

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Jefferson Smith

11 BIRTHPLACE OF FATHER (city or town) Unk
(State or country)

12 MAIDEN NAME OF MOTHER Maggie Richardson

13 BIRTHPLACE OF MOTHER (city or town) Unk
(State or country)

14 Informant Archie Smith
(Address) 2100 Frazier

15 Filed ..., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death by ..... (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Sudden
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) Harry Roth M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 5/14 1930

20 UNDERTAKER Samuel Kennedy 578 N Broadway

ADDRESS

MAY 14 1930 REGISTRATION DEPARTMENT

Spec.—1-30—M. & T.—250 Bks.

E 57157 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 57157

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 306 N Schroder St. 18-26 WARD)

2-FULL NAME Alberta B. Jackson

(a) RESIDENCE NO. 306 N. Schroder St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter S. Jackson

7 DATE OF BIRTH (month, day, and year): Sept 4- 1885

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	2	28	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Va

10 NAME OF FATHER: Erasmus T. Brown Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Helen Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

Informant: Walter S. Jackson husband
(Address) 306 N. Schroder St

Filed OCT 4 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12 30

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to May 12, 1930, that I last saw her alive on May 12, 1930, and that death occurred, on the date stated above, at 11-20 P m.

The CAUSE OF DEATH* was as follows:
Chronic interstitial Nephritis

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage
(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Battle M. D.
(Address) 817 Hamburg Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem | DATE OF BURIAL: May 15 1930

20 UNDERTAKER: Emmett Hensley | ADDRESS: 1128 Riddle St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57158

CERTIFICATE OF DEATH.

1930 ✓

E 57158

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 910 N. Carey St. 16-23 (WARD)

2-FULL NAME Edwin Murray

(a) RESIDENCE NO. 910 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Maria L. Murray

DATE OF BIRTH (month, day, and year) March 1877

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	2		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Yard Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) 035

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Lancaster Co Va

10 NAME OF FATHER Jeremiah Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Estelle Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Co Va

Informant Maria L. Murray

(Address) 910 N. Carey St

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11-30

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 11, 1930, that I last saw him alive on May 11, 1930, and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

Heat prostration

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) — yrs. — mos. 2 hours ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pelton, M. D.

, 19 (Address) 817 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 14, 1930
20 UNDERTAKER Samuel K. Feasley	ADDRESS 1711 Eutaw Pl

Spec.—1-10-21—M&T—1500 Blks.

57159

HEALTH DEPARTMENT—CITY OF BALTIMORE

Joseph W. F. Tabeling

CERTIFICATE OF DEATH.

101-001

E 57159

REGISTERED NO.

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE, (No. Caroline & Monument 07-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph W. Tabeling

(a) RESIDENCE NO. 4710 Old York Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed or divorced HUSBAND of ~~the late~~ (or) ~~WIFE~~ of Katherine Tabeling

6 DATE OF BIRTH (month, day, and year) April 17 1865

7 AGE: Years 65 | Months — | Days 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Motorman

(b) General nature of industry, business, or establishment in which employed (or employer): for United Railway

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Gerhardt H. Tabeling

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Margaret Decker

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Mrs Ida Lowry (Address) 4710 Old York Road

15 Filed MAY 14 1930, 19 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-12- 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-4 , 1930 , to 5-12 , 1930 , that I last saw h~~er~~ alive on 5-12 , 1930 , and that death occurred, on the date stated above, at 4 PM m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Cardiac failure Psychosis (toxic)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? clinical & autopsy

(Signed) M B Hendrix M. D.

Address 5/12, 1930 4710 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: May 15 1930

20 UNDERTAKER: Henry Hock (Inc) — ADDRESS: 1301 E Eager St

1 47 1930

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57160 — 1-22-90

E 57160 REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Levi Hannan

(a) RESIDENCE NO. 1509 W. Lanvale St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
64	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto City

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Matilda Geor
(Address) 1507 W Lanvale St

Filed 1 4 1930 C. HAMILTON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry find that said deceased came to death by Inquest, autopsy or inquiry,
on the day stated above.
The CAUSE OF DEATH* was as follows:

M. Myocarditis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? No

What were conditions found? Ep

What was confirmed diagnosis? Ep

(Signed) C. Blades, M. D.

19 (Address) 143 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 5-14 1930

20 UNDERTAKER Saml Eaton

ADDRESS Dover

Spec.—1-30—M. & T.—250 Bks.

E 57161 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57161

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 10-14 WARD)

CITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Males

(a) RESIDENCE NO. 718 N. Gay st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Edgar Males

DATE OF BIRTH (month, day, and year) 1891 Sept. 4

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	8	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife g37

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER James Cumings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary Hershberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Records
(Address)

Filed 5-14 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1930, to May 12, 1930, that I last saw her alive on May 12, 1930, and that death occurred, on the date stated above, at 8.45 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno Stevens Jr M. D.

5-13 1930 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL May 6 1930

UNDERTAKER George N. Zirkler — ADDRESS 1737 E. Eager st

Spec.—1-30—M. & T.—250 Bks.

E 57162 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57162

CERTIFICATE OF DEATH.

REGISTERED NO. 167

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Nicoll

(a) RESIDENCE NO. 2041 E Walth Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) May 13 30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				6 hrs.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto Md (State or country)

10 NAME OF FATHER William Donaldson Nicoll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Edith Elliott

13 BIRTHPLACE OF MOTHER (city or town) P.G. (State or country)

Informant C. E. Douglas

(Address) Johns Hopkins Hospital

Filed 1 4 1930 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13/30

17 I HEREBY CERTIFY, That I attended deceased from May 13/30, 19.., to May 13/30, 19.., that I last saw h.. alive on May 13/30, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows: Premature Inf

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. E. Douglas M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt Covington

DATE OF BURIAL May 14, 1930

UNDERTAKER H. Ger. H. Tittle

ADDRESS Baltimore

Spec.—1-30—M. & T.—250 Bks.

E 57163 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 57163

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ..... ST. 18-29 WARD)

2-FULL NAME Mary Bowen

(a) RESIDENCE NO. 902 Lemmon ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

6 If married, widowed, or divorced (or) WIFE of Wm Bowen

7 DATE OF BIRTH (month, day, and year) Aug. 19-1886

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
(43)	43	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Benj F. Childs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER ? Lemmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant John H. Wells

(Address) 600 Cromwell Apts Towson, Md

Filed AY 14 1930 HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 13, 1930, that I last saw h[er] alive on May 13 1930, and that death occurred, on the date stated above, at 12 45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Zuyko, M. D.

5/13, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cem — DATE OF BURIAL May 15 1930

20 UNDERTAKER Harry H Witzke — ADDRESS 4191 Edmondson Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 57164

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 57164

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Bruhn

(a) RESIDENCE NO. 2837 W Lanvale St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 25 1914

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	8	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Hugo N. Bruhn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susana Yocker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hugo Bruhn

(Address) 2837 W Lanvale St

4 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-13-30

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to May 13, 1930, that I last saw h[illegible] alive on May 13, 1930 and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Rheumatic heart disease

(duration) yrs. mos. 42 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

Congestion (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Louis P. Gundry, M. D.

5-13-1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL May 15 1930

UNDERTAKER Erich Sefer

ADDRESS 1600 N. Howard St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57165 88 E 57165

CERTIFICATE OF DEATH

REGISTERED NO. 13-59

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 800 Chauncey Ave WARD)

2—FULL NAME Frances Kerngood Kaufman

(a) RESIDENCE NO. 800 Chauncey Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth 30 rs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Kaufman

DATE OF BIRTH (month, day, and year) Oct. 7, 1865

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany.

10 NAME OF FATHER H. Kerngood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Eichenwald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

Informant Mrs. J. Trout

(Address) Mt. Royal Terrace

Filed 4 1930 CHAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14-1930

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 13, 1930, that I last saw h alive on May 13, 1930 and that death occurred, on the date stated above, at 1 9 m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 223 E Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 5/16/1930

UNDERTAKER Harry Sondheim

ADDRESS 115-20 W. Mt. Royal Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 57166

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH

E 57166

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George A Brown

(a) RESIDENCE NO. 1024 Wilmer ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Pearl Brown

DATE OF BIRTH (month, day, and year) 1896

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Chas. T. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Pearl C. Brown

(Address) 1024 Caroline St

Filed 4 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-12-30

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to May 12, 1930, that I last saw h[illegible] alive on May 12, 1930 and that death occurred, on the date stated above, at 7 3/4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) about 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M. St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

20 UNDERTAKER Theodore C. White

DATE OF BURIAL May 15th 1930

ADDRESS 1138 N. Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

E 57167 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57167

CERTIFICATE OF DEATH. + 70

1-PLACE OF DEATH St Agnes Hospital REGISTERED NO. 45-T

CITY OF BALTIMORE: (No. Caton & Wilkes Avenues ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Seiss

(a) RESIDENCE NO. Thurmont. Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 19 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Emmitsburg

PARENTS

10 NAME OF FATHER Charles Seiss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles Seiss (Address) Thurmont Md

15 Filed 4 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-14 — 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-25, 1930, to 5-14, 1930, that I last saw him alive on 5-14, 1930, and that death occurred, on the date stated above, at 9 35 a.m. E.S.T.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. 1 mos 19 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Ernest Spencer p. M. D.

19 (Address) St agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmitsburg Md — DATE OF BURIAL May 16 1930

20 UNDERTAKER M. F. Shuff Jr — ADDRESS Emmitsburg Md

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57168

E 57168

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Hotel Belvedere ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas A. Cross

(a) RESIDENCE NO. Hotel Belvedere ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

DATE OF BIRTH (month, day, and year) ---------

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
Correct age not known Between 60 and 66 years			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vice President

(b) General nature of industry, business, or establishment in which employed (or employer) United Railway

(c) Name of employer Company

BIRTHPLACE (city or town) (State or country) Prince George Co. Maryland

10 NAME OF FATHER Thomas H. Cross

11 BIRTHPLACE OF FATHER (city or town) ------ (State or country) Maryland

12 MAIDEN NAME OF MOTHER Arrabella Duvall

13 BIRTHPLACE OF MOTHER (city or town) ----- (State or country) Maryland

Informant Mrs. Belle C. Slingluff

(Address) 2432 N. Charles Street

Filed C. HAMPSON JONES, M. D. Registrar.

4 1930 By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1930

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 13, 1930, that I last saw h... alive on May 13, 1930 and that death occurred, on the date stated above, at 3:45 P m.

The CAUSE OF DEATH* was as follows: Pneumonia (Bronchial)

(duration) 1 yr. mos. 6 da.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy (duration) ... mos. ... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) J. H. Bradley, M. D.

, 19 (Address) 1403 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 5/15 1930

20 UNDERTAKER Henry W. Mears and Son

ADDRESS 805 N. Calvert

Spec.—1-30—M. & T.—250 Bks.

E 57169 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57169

CERTIFICATE OF DEATH. 25-002

REGISTERED NO. .....

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 517 W. Biddle ST. 17-24 WARD)

2-FULL NAME Ellen Armstrong

(a) RESIDENCE NO. 517 W Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col—	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Not Known

DATE OF BIRTH (month, day, and year) 1855

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
75	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Maryland—Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md—Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md—Unknown

Informant Mattson Biddle St—

(Address) Address 517 W Biddle St

Filed 4-1930 J. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14/30

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 14, 1930 that I last saw her alive on May 13—1930 and that death occurred, on the date stated above, at 7 A— m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral —
(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel A. Daw, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 5/15 1930

20 UNDERTAKER Samuel A. Hemsley

ADDRESS 517 W Biddle

Spec.—2-29-28—L. F. S.—500 Bks.

E 57170 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57170

CERTIFICATE OF DEATH

REGISTERED NO. 24

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 Diamond St., 17 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hunter Lewis

(a) RESIDENCE NO. 404 Diamond ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced: HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year): 1885

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 640

(c) Name of employer:

BIRTHPLACE (city or town) Thacker W Va

10 NAME OF FATHER Henry Lewis

11 BIRTHPLACE OF FATHER (city or town) W Va.
(State or country)

12 MAIDEN NAME OF MOTHER Louisa Williams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) W Va

Informant Carrie Ward

(Address) 424 Diamond St.

Filed 4-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 12, 1930, that I last saw him alive on May 12, 1930, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) J. E. Cawley, M. D.

19 (Address) 532 Lemmon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem

DATE OF BURIAL: 5/16/30

20 UNDERTAKER: Samuel F. Hemler

ADDRESS 1128 Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57171

REGISTERED NO. E 57171

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 3707 Harmon St. 28-6 (Ward)

2-FULL NAME Eugene Pfeiffer

(a) RESIDENCE NO. 3707 Mahadden St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) June 1925

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	4	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Eugene Pfeiffer

11 BIRTHPLACE OF FATHER (city or town) Balt
(State or country)

12 MAIDEN NAME OF MOTHER Marie Bezold

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country)

14 Informant Eugene Pfeiffer
(Address) 3707 Mahadden

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide Shotgun wound of chest & abdomen

(duration) yrs. Instantaneous

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy M. D.

(Signed) Coroner

(Address) May 11 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 5/15/30

20 UNDERTAKER Engel & Daly

ADDRESS Baltimore Maryland

1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57172

REGISTERED NO. 191 ✓ E 57172

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 3707 Warren St. 28-64 Ward)

2-FULL NAME Jane Frances Pfeiffer.

(a) RESIDENCE NO. 3707 Warren St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Apr 26 - 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	—	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Eugene Pfeiffer

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Marie Bezold

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Eugene F Pfeiffer
(Address) 3707 Warren St

15 Filed May 16 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide
Hemorrhage Lungs
Pistol wound of Head
& Lung. (duration) Sudden
Shot

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3707 Warren

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Inspection

(Signed) H. Beecke, M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	5/15/30
20 UNDERTAKER Fred C Talley	ADDRESS Eutaw & Fayette

Cor.—10-10-29—A Co.—100 Bks.

(Mitchell & Schloffer)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57173

CERTIFICATE OF DEATH

E 57173

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2414 Whitelock St., Ward)

2-FULL NAME Mitchell Schloffer

(a) RESIDENCE NO. 2414 Whitelock St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Schloffer

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
67	—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter Worker
(b) General nature of industry, business, or establishment in which employed (or employer) 0&6
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER John Schloffer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mary M. Schloffer
(Address) 2414 Whitelock St.

15 Filed ..., 1930 C. HAMPSON JONES, Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fell down steps Fractured femur Pleurisy & Hydro Thorax right lung

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O'Donovan, M. D.

5/14, 1930 (Address) 3601 3rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL 5/16/30

20 UNDERTAKER Joseph Stanley Schloffer

Cor.—10-10-29—A Co.—100 Bks.

Elmer Domski

E 57174

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57174

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospitals St., Ward)

2-FULL NAME Elmer Kenneth Domski

(a) RESIDENCE NO. 2425 Fait Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25 28

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	6	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) South Carolina

PARENTS

10 NAME OF FATHER Robert Domski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Bertha Sickinska

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Robert Domski
(Address) 2425 Fait Ave

15 Filed ....., 19 C. HAMPSON JONES, Registrar
4 1930 Reg. No. 1014

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) 6 yrs. mos. 2 da.

CONTRIBUTORY (Secondary) C & Laceration

(duration) yrs. mos. 1 da.

18 Where was disease contracted — —
If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No History

What was confirmed diagnosis? May 4 1930

(Signed) C C Glades, M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	May 5 1930
20 UNDERTAKER	ADDRESS
F W Brazenski	1930 Eastern Ave.

Spec.—1-12-23—M&T—500 Blks.

E 57175

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57175

CERTIFICATE OF DEATH.

60-82

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W. Balto. Gen. Hosp. ST., 9-10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Joseph Eder

(a) RESIDENCE NO. 514 N. Monteford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Eder

6 DATE OF BIRTH (month, day, and year) March 7, 1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Francis J. Eder

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Mary M. Francis

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country) Not known

14 Informant Margaret Eder

(Address) 514 N. Monteford Ave.

C. HAMPSON JONES, M. D.

4 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/27/ , 1930 , to 5/12/ , 1930 , that I last saw h[illegible] alive on 5/12/ , 1930 , and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Auricular fibrillation

(Myocardial degeneration)

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 5/9/30

Was there an autopsy?

What test confirmed diagnosis? Clinical sign

(Signed) J. V. Castagna, M. D.

, 19 (Address) W. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mathews Cem. DATE OF BURIAL May 15 1930

20 UNDERTAKER Wm. C. Christian Miller & Son ADDRESS 2334 E. Jeffer St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

+ 123 E 57176

E 57176

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (NO. Caroline & Eden ST.) (9-17 WARD)

2-FULL NAME Mrs. Bessie Smith

(a) RESIDENCE NO. Forest Hill, Maryland WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John N Smith

6 DATE OF BIRTH (month, day, and year) Apr 22 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Md

PARENTS

10 NAME OF FATHER Wm Witts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Bessie Clark

13 BIRTHPLACE OF MOTHER (city or town) Hartford Co (State or country)

14 Informant Mattie Gray

(Address) Forest Hill

15 Filed 5 15 1930 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-14 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-7, 1930, to 5-14, 1930, that I last saw her alive on 5-14, 1930, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Empyema of Gall Bladder.
Cholelithiasis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5-12-30

Was there an autopsy? No

What test confirmed diagnosis? Operation & Clinical Findings

(Signed) W. B. Hendrix M. D.

. 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Centre Cemetery Forest Hill

DATE OF BURIAL May 17 1930

20 UNDERTAKER L. G. Krug & Son

ADDRESS Forest Hill Md

Spec.—1-30—M. & T.—250 Bks.

E 57177. HEALTH DEPARTMENT—CITY OF BALTIMORE E 57177

11-002

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1190 W. Mosher St. 11th (Ward)

2-FULL NAME Mary L. Medinger

(a) RESIDENCE NO. 1190 W. Mosher St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) June 30 1848

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	10	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) Balto
(State or country) Md

10 NAME OF FATHER Jno. W. Medinger

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Jane Johnston

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

Informant George W. Medinger

(Address) 1190 W. Mosher St.

Filed MAY 5 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1930

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1927, to May 13, 1930, that I last saw her alive on May 13, 1930, and that death occurred, on the date stated above, at 9.12 a.m.

The CAUSE OF DEATH* was as follows:

Senile myocarditis

(duration) Some yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) George W. Mosher, M. D.

5/14 1930 (Address) 2405 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL/CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL May 15 1930

UNDERTAKER Wm. Tucker Sons ADDRESS North & Pa

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 57178

E 57178

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Church Home & Infirmary St., 26-37 Ward)

2-FULL NAME Jacob Bader

(a) RESIDENCE NO. 718 S.Grundy St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bettie

6 DATE OF BIRTH (month, day, and year) March 2/1876

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	54	2	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coppersmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Balto. Co., Md.

PARENTS

10 NAME OF FATHER John Bader

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy ------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mary C. Weber
(Address) 1825 N. Rutland Ave

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Aneurysm of Ascending Aorta.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Church Home

What test confirmed diagnosis?

(Signed) [signature], M. D.

5/13/1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL 5/16/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57179

E 57179

CERTIFICATE OF DEATH.

129

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hospital St. WARD)

2-FULL NAME Mrs Mollie Germeten

(a) RESIDENCE NO. 2539 Francis ST. H WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of R. J. Germeten

6 DATE OF BIRTH (month, day, and year) June 18 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md Pa.
(State or country)

PARENTS

10 NAME OF FATHER Julius Schaumetka

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Hospital Records
(Address)

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1930

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to May 14, 1930, that I last saw her alive on May 14, 1930, and that death occurred, on the date stated above, at 1.05 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. 14 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. Robert Wells, M. D.

, 19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine

DATE OF BURIAL 5/17 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Pratt St

MAY 15 1930 C. HARRY JONES, M. D.

For

Cor.—10-10-29—A Co.—100 Bks.

2989 - McElderry

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57180

CERTIFICATE OF DEATH

E 57180

REGISTERED NO. 188

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Franklin Square Hospital St. 25-68 Ward

2-FULL NAME William Melvin Sacks

(a) RESIDENCE NO. 1645 N. Spallwood St

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3. 1924

7 AGE: Years 5 | Months 10 | Days 10 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Melvin Sacks

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Erma Sacks

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Melvin Sacks
(Address) 1645 N. Spallwood St

15 Filed MAY 5 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows: Run over in front of Franklin auto moving

ae Fract Skull (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Spallwood nr Western
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Coroner
(Signed) C. Hampson Jones, M. D.
5/1/30 (Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 5/7 1930

20 UNDERTAKER William Cook

ADDRESS 1219 E. Pratt St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57181

E 57181

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 6-10 (Ward)

2-FULL NAME Roland B. Saylor

(a) RESIDENCE NO. 234 N. Kenwood St., Ward Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 14/1928

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	2	0	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Harrisburg, Pa.

PARENTS

10 NAME OF FATHER Roland B. Saylor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Gwendolyn Vaughn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Roland B. Saylor.
(Address) 234 N. Kenwood Ave.

15 Filed MAY 15 1930. 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Purulent Meningitis. Fracture Skull. Piece of ice box accidently fell on child in rear of 219 N. Belnord Ave - May 11/30

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? At Hopkins Hospital

What test confirmed diagnosis?

(Signed) [illegible], M. D.

5/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrisburg Pa

DATE OF BURIAL 5/15 1930

20 UNDERTAKER Joseph Abrams

ADDRESS 324 E Preston

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57182 | 101-001 | REGISTERED NO. E 57182

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 Rear alley, ST., 5-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Grant

(a) RESIDENCE NO. 1309 N Allen ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C.	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Stella Grant

DATE OF BIRTH (month, day, and year) 1884

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) United States

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unk

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk

Informant Mrs Johnson

(Address) 1309 N Allen

Filed May 15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13-30

17 I HEREBY CERTIFY, That I attended deceased from May 3 1930, to May 12 1930, that I last saw him alive on May 12 1930, and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Jno Sallen, M. D.

5-14 1930 (Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mokey Neck Cemetery

DATE OF BURIAL May 15 1930

20 UNDERTAKER Lottie Gross

ADDRESS 1408 Ashland Ave

Spec.—1-12-23—M&T—500 Bks.

E 57183 HEALTH DEPARTMENT—CITY OF BALTIMORE 86 E 57183

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital ST.; WARD

2-FULL NAME Gertrude Douglas.

(a) RESIDENCE NO. 911 Harewood Ave ST.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9-1910

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
20	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Douglas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hester Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs John Douglas (Address) 709 Sterling St

15 Filed 1930 C. HA[illegible]ONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1930

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1930, to May 14, 1930,

that I last saw h[illegible] alive on May 14, 1930,

and that death occurred, on the date stated above, at 3.45 a.m.

The CAUSE OF DEATH* was as follows:

Subacute (Bacterial Endocarditis

(duration) yrs. 3 mos [illegible] ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of

Was there an autopsy? Yes. 5/14/30

What test confirmed diagnosis? Clinical + autopsy

(Signed) E. H. Resse, M. D.

, 19 (Address) West Balto Grd Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart [illegible] DATE OF BURIAL May 15. 30

UNDERTAKER John J. Fahey Sons ADDRESS 318 Light St

Spec.—1-10-21—M&T—1500 Bks.

E 57184 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57184

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 16-67 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas C. Bowen

(a) RESIDENCE NO. 1702 Ellamont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. 9 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	9	21	

8 OCCUPATION OF DECEASED None.

(a) Trade, profession or particular kind of work Student of

(b) General nature of industry, business, or establishment in which employed (or employer) vocal music

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Thomas E. Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Margaret Hughen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Hospital Records

(Address)

15 Filed 5 1930 G. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1930

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1930, to May 15, 1930, that I last saw him alive on May 15, 1930, and that death occurred, on the date stated above, at 4 45 A.m.

The CAUSE OF DEATH* was as follows:

Acute gangrenous appendicitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of May 11, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Laboratory

(Signed) John A. Lanahan M.D.

(Address) 136 Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	May 17 1930
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons	Race

Spec.—2-29-28—L. F. H.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 57185

REGISTERED NO. E 57185

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 E. 20th ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katie Lefus

(a) RESIDENCE NO. 28 E. 20th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C.	Widow

If married, widowed, or divorced RUSBAND of (or) WIFE of Lefevre

DATE OF BIRTH (month, day, and year) Unknown 1875

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
45	45			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mary Lewis

(Address) 28 E. 20th St.

Filed 5 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 30

17 I HEREBY CERTIFY, That I attended deceased from May 3 1930, to May 12, 1930, that I last saw her alive on May 12, 1930, and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. A. Johnson, M. D.

19 (Address) 2359 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Berlin Md.	May 15 1930
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1225 Ashland

Spec.—1-30—M. & T.—250 Bks.

E 57186 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57186

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 12-19 ST. WARD)

2-FULL NAME Arthur Campbell

(a) RESIDENCE NO. 426 Worsley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Elnora Campbell

7 DATE OF BIRTH (month, day, and year) Dec. 18, 1881

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	4	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Asa Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Willie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Records of

(Address) Balto. City Hosp.

Filed 1-5 1930 C. HARROLD JONES, M. D. Registrar

By Riley

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-11-30

17 I HEREBY CERTIFY, That I attended deceased from 5-3-30, 19..., to 5-11-30 19...,

that I last saw h. alive on 5-11-30, 19...,

and that death occurred, on the date stated above, at 2:20 A.m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic

(duration) over 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic; hypertension (duration) yrs. over 8 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harvey M. McLean, M. D.

5/12, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Crem Va

DATE OF BURIAL May 15 1930

20 UNDERTAKER Mrs. R. G. Ellard

ADDRESS 1725 Washington Ave

Spec.—8-16-29—L. P. S.—100 Blks.

236 E 35 med 57187 HEALTH DEPARTMENT—CITY OF BALTIMORE 99-002 E 57187

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Wermuth

(a) RESIDENCE NO. 2231 E Fayette ST., WARD

(Usual place of Abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	~~Single~~ widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) ~~mar 23 86~~ unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work odd jobs

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Michael Wermuth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Josephine Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 5 1930, 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14-1930

17 I HEREBY CERTIFY, That I attended deceased from May 2, 19 30, to May 14, 19 30,

that I last saw him alive on May 14, 19 30

and that death occurred, on the date stated above, at 7 40 a. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

Acute jaundice

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Contemporaneous failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin

(Signed) R. Gordon Douglas, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk

DATE OF BURIAL 5/17 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

Spec.—1-30—M. & T.—250 Blks.

E 57188

E 57188

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 611 N. Collington Ave ST. 17-10 (WARD)

2-FULL NAME Wilhelmina Lehmann

(a) RESIDENCE NO. 611 N. Collington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Wm A. F. Lehmann

DATE OF BIRTH (month, day, and year) Oct 2/1843

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	7	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER — Bülage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Lang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs F. C. W. Lehmann

(Address) 611 N. Collington Ave

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MAY 15 1930 AT .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13/30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1930, to May 13, 1930, that I last saw h[illegible] alive on May 13, 1930, and that death occurred, on the date stated above, at 12 15 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Joseph Pokorny, M. D.

, 19 (Address) 1200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

20 UNDERTAKER Philip Herwig

DATE OF BURIAL May 16 1930

ADDRESS 2016 Eutaw St

Spec.—1-12-23—M&T—500 Bks.

E 57189 HEALTH DEPARTMENT—CITY OF BALTIMORE 47 E 57189

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Hollins St. ST. 14-28 WARD)

2-FULL NAME Elizabeth L. Fullum

(a) RESIDENCE No. 1614 Hollins St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Frank R. Fullum

6 DATE OF BIRTH (month, day, and year): Nov. 22, 1890

7 AGE — Years: 39 — Months: 5 — Days: 22 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Pa.

10 NAME OF FATHER: John Gutridge

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

Informant: Mr. Frank R. Fullum
(Address) 1614 Hollins St.

Filed ....., 19 .....

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 4th., 1930, to May 12th., 1930, that I last saw her alive on May 12th., 1930, and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast and lung

(duration) ..... yrs. 10 mos ..... ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Edw Woodlaber, M. D.

5/15 1930 (Address) 24 N. Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: May 17 1930

20 UNDERTAKER: John J. Cowan & Son — ADDRESS: 901 Hollins St

Spec.—1-30—M. & T.—250 Bks

E 57190 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57190

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Mem. Hosp. ST. 26-39 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Juanita White

(a) RESIDENCE NO. 3504 E. Fairmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 30 1918

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	11	15	

OCCUPATION OF DECEASED School

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Virgil White

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Lucia Baughan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Mary White

(Address) 3504 E. Fairmount

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/15/30

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 15, 1930,

that I last saw her alive on May 14, 1930

and that death occurred, on the date stated above, at 5:15 A.m.

The CAUSE OF DEATH* was as follows:

hydronephrosis (congenital abnormality of kidney)

(duration) 11 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) chronic nephritis (with uremia)

(duration) 3 yrs mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? cystoscopy + autopsy

(Signed) A. H. Swartzwelder, M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL May 17, 1930

20 UNDERTAKER W. John Merrick

ADDRESS 2008 Eutaw

C. HAMPTON JONES

Spec.—1-30—M. & T.—250 Bks.

E 57191 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 57191

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp. ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Ely

(a) RESIDENCE NO. 502 Wedcome Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

7 DATE OF BIRTH (month, day, and year) 1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73 72?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Tom Berres

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hospital Record

(Address)

Filed 19 C. P. KOONTZ JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-13-30

17 I HEREBY CERTIFY, That I attended deceased from 1-15, 1930, to 5-13, 1930, that I last saw him alive on 5-13, 1930, and that death occurred, on the date stated above, at 11 55 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma urinary bladder

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. C. Pumphrey, M. D.

5-14, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL May 15 1930

UNDERTAKER David Carter ADDRESS 916 E Pratt

Spec.—1-10-21—M&T—1500 Bks.

E 57192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 57192

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. ... ST. ... WARD) 16-67

REGISTERED NO. ... (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. John L Vaeth

(a) RESIDENCE NO. Balt 2920 Riggs Ave ST. ... WARD ...
(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 4 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) 12/14/58

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	71	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hardware

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Francis Vaeth (Address) 2920 Riggs Ave

15 Filed 5-15-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-13 1930.

17 I HEREBY CERTIFY, That I attended deceased from 3-18, 1930. to 5-13, 1930.

that I last saw him alive on 5-13, 1930,

and that death occurred, on the date stated above, at 10 45 pm.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL May 16 1930

20 UNDERTAKER Richard W Meyer — ADDRESS Baltimore

Spec.—8-16-29—L. F. S.—100 Bks.

E 57193 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57193

CERTIFICATE OF DEATH 31

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 Clifton Ave. ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George H. Mettle

(a) RESIDENCE NO. 1829 Clifton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or WIFE of) Irene (Will) Mettle

DATE OF BIRTH (month, day, and year) Aug 10 1883

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	9	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Joseph H. Mettle

(Address) 1829 Clifton Ave.

Filed 5/15, 19 30 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13-1930

17 I HEREBY CERTIFY, That I attended deceased from May 3rd, 1930, to May 13th, 1930, that I last saw him alive on May 13th, 1930 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

C

(duration) Old yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Bacteriology

(Signed) M. Sullivan, M. D.

5/14, 1930 (Address) 1701 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL May 16 1930.

20 UNDERTAKER Martin Bailey & Sons

ADDRESS 1827 N. West Ave

Cor.—10-10-29—A Co.—100 Bks.

E 57194

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57194

CERTIFICATE OF DEATH

170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 6-10 Ward)

2-FULL NAME Samuel Grebow

(a) RESIDENCE NO 19 N. Milton Ave.. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 rs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Grebow

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Aaron Grebow

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie -----

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant S. Grebow (Brother)

(Address) 2522 Keyworth Ave..

15 Filed 5/15/30 [signature] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 May 14/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol Shot Wound Rt. Temple

Suicide

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

5/15/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmount Russdale — DATE OF BURIAL 5-15- 1930

20 UNDERTAKER Jack Levin, 1739 E Balt. — ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 57195

Dr Norris 106 E West St ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57195

CERTIFICATE OF DEATH.

129

REGISTERED NO. 36-41

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4213 Frankford Ave ST. WARD)

2-FULL NAME John E Sipek

(a) RESIDENCE NO. 4213 Frankford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6 If married, widowed, or divorced HUSBAND of or) WIFE of Katherine Sipek

7 DATE OF BIRTH (month, day, and year) Jan 22.1856

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	3	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Joseph Sipek

(Address) 4213 Frankford Ave

Filed ..... 19 ..... C. HAMPSON JONES, Registrar.

MAY 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15.1930

17 I HEREBY CERTIFY, That I attended deceased from 5.7.30, 19..., to 5.15., 19 30, that I last saw him alive on 5.14., 19 30, and that death occurred, on the date stated above at 2309 m.

The CAUSE OF DEATH* was as follows:

Pastern Standard Time

Chronic Nephritis

Myocarditis

Cardiac Hypertension

(duration) I don't know

CONTRIBUTORY (Secondary) uremia

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Norris M.D.

5.15. 19 30 (Address) 107 East west st

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Cathedral

DATE OF BURIAL 5/17 1930

20 UNDERTAKER W. M. Cook

ADDRESS 1214 E Pratt St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-008

L 57196

L 57196

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Victor Buczkowski.

(a) RESIDENCE NO. 837 S. Bond St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of WIFE of Julianna Buczkowski

6 DATE OF BIRTH (month, day, and year) October 17, 1882

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	47	6	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer) 07
(c) Name of employer

9 BIRTHPLACE (city or town) Poland.
(State or country)

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Julianna Buczkowski, (wife)
(Address) 837 S. Bond St.

15 Filed , 1930 , Registrar

15 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of the intestines. Struck in the abdomen by an iron handle of a wagon. Occidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pier 6 Locust Point. Nov 11, 1930

Did an operation precede death? Yes. Date of Nov 11, 1930

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) H. L. Leonhardt, M. D.

5/14, 1930 (Address) 1015 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cemetery	May 17 1930
20 UNDERTAKER	ADDRESS
George R. Weber	705 S. Ann St

Spec.—1-30—M. & T.—250 Bks.

E 57197 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57197

101-004

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (NO. 713 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Fannie Rice

(a) RESIDENCE NO. Sinai Hospital ST., Old Fallos Home WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) June 4, 1853

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	11	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Store

(b) General nature of industry, business, or establishment in which employed (or employer): Buyer of

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Penn.

10 NAME OF FATHER: Marcus Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Celia Kennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Mr. F. Deutsch

(Address) 5503 Merville Ave

Filed 5 1930, 19 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/14/30

17 I HEREBY CERTIFY, That I attended deceased from 5/6, 1930, to 5/14, 1930

that I last saw her alive on 5/6, 1930,

and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Rt)

(duration) yrs. mos 8 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Sinai

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) A. A. Gilbert, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Har Sinai Cem.

DATE OF BURIAL: 5/16/1930

ADDRESS 1119 W. Mt. Royal Ave

20 UNDERTAKER: Levi Sondheim

Spec.—1-30—M. & T.—250 Blks.

E 57198 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57198

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 4-18 ST., 6 WARD)

2-FULL NAME Robert F. Patterson

(a) RESIDENCE NO. 904 Preston St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of -

DATE OF BIRTH (month, day, and year) 1854

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto.

(State or country) Md.

10 NAME OF FATHER Robert Patterson

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Janie Elliott

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

Informant Records of

(Address) Balto. City Hosp. UNIV

Filed 5-13 19 30 C. HAMPSON JONES, M. D. Registrar IV

11:53 P.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-12-30

17

I HEREBY CERTIFY, That I attended deceased from 1-7-30, 19..., to 5-12-30, 19...,

that I last saw him alive on 5-12-30, 19...,

and that death occurred, on the date stated above, at 12:10 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) over 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) over 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harvey M. McLean, M. D.

5-13, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Baltimore City Health Department

ADDRESS MAY 15 1930

Spec.—1-30—M. & T.—250 Bks.

E 57199 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57199

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 10-14 ST. WARD)

2-FULL NAME Elizabeth Bonner

(a) RESIDENCE NO. 835 Wilmot St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced (or) WIFE of HUSBAND of David

DATE OF BIRTH (month, day, and year) June 15, 1889

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Michael ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Loftus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Records of (Address) Balto. City Hosp.

Filed 5-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-15-30

17 I HEREBY CERTIFY, That I attended deceased from 5-13-30, 19..., to 5-15-30, 19...,

that I last saw her alive on 5-15-30, 19...,

and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:

Thrombosis, Chronic Endocarditis, Chronic Acute

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis, Chronic over 3 mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harvey W. McLean, M. D.

5-15, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincents Cemetery DATE OF BURIAL 5/17/30

20 UNDERTAKER Jno Cook ADDRESS 1217 St Paul St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57200 E 57200

CERTIFICATE OF DEATH.

117

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hosp

CITY OF BALTIMORE: (No.) Howard & Madison ST., 20-69 WARD)

2-FULL NAME Clara V. Streett Mrs. Clara V. Streett

(a) RESIDENCE NO. 38 28 S Pulaski ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William C. Streett

6 DATE OF BIRTH (month, day, and year) Sept. 27, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	71	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Erastus R Snow

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Stiner

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs. Nellie Rosenwinkle Long Record
(Address) 28 S. Pulaski St.

15 5 1930 G. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1930

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1930, to May 15, 1930, that I last saw h alive on May 15, 1930, and that death occurred, on the date stated above, at 9 20 a.m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 14, 1930

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H W Kerschner M. D.

5/15, 1930 (Address) Md General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 17 1930

20 UNDERTAKER L B Cook

ADDRESS 1003 West Baltimore St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57201

CERTIFICATE OF DEATH

118-002

E 57201

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 625 N. Calhoun St., 16-26 Ward)

2-FULL NAME Gloine Chajin

(a) RESIDENCE No. 625 N. Calhoun St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of NO

6 DATE OF BIRTH (month, day, and year) Aug 11 1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	9	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Moses Chajin

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Beatrice Ford

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Beatrice Chajin
(Address) 625 N. Calhoun

15 Filed 5 1930 C. HAMILTON JONES, M. D. Registrar

Rec 1068

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) C. Blank M. D. Coroner

(Address) 5/14/30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 5/16/1930

20 UNDERTAKER Jno. Geo. H. Holland — ADDRESS 1631 Druid Hill Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57202

CERTIFICATE OF DEATH

74-001 ✓

E 57202

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 617 Springfield Ave St., 27-47 Ward)

2-FULL NAME Ambrose Beauregard Mullan

(a) RESIDENCE NO. 617 Springfield Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Caroline Mullan (Evans)

6 DATE OF BIRTH (month, day, and year) Nov 24/1861

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	68	5	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Printer
(b) General nature of industry, business, or establishment in which employed (or employer) 63
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Paine Mullan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Emily S. Adams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Mrs. A. B. Mullan
(Address) 617 Springfield Ave

15 Filed 5 193[illegible] 16 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ?

(Signed) [illegible] M. D.

(Address) 508 E. North Ave 5/15/30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	5/16 1930
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E Balto

Spec—12-23-21—E.B.R.S.—400 Bks.

E 57203

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57203

CERTIFICATE OF DEATH.

Registered No. 122

1-PLACE OF DEATH

City of BALTIMORE: (No. 2507 W. North Ave St. 15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta N. Dell

(a) Residence No. 2507 W. North St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 4 1853

7-AGE, 76 9 11

77 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James M. Stephens

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Charlotte Cuthcam

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) George Dell

(Address) 2507 north ave

15- C. HAMPSON JONES, M. D.

MAY 5 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 15 1930

17- I HEREBY CERTIFY, That I attended deceased from Nov 7, 19 27 to May 13, 19 30,

that I last saw her alive on May 13, 19 30,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) L. C. Colby, M. D.

, 19 (Address) 3517 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL, 5/19 1930

20-UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

E 57204

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57204

CERTIFICATE OF DEATH

REGISTERED NO. 111-001

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 516 Hurley Lane ST. 20-18 WARD)

2—FULL NAME John L. Farrar

(a) RESIDENCE NO. 516 Hurley Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND (or) WIFE of: Harriet Childs Farrar

DATE OF BIRTH (month, day, and year): Aug 21, 1899

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	8	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lithographer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Balto, Md

10 NAME OF FATHER: Frank M. Farrar

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Carrie Holestich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Frank M. Farrar

(Address) 2117 Wilkens Ave

C. HAMPSON JONES, M. D. Registrar

5-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/15/30.

17 I HEREBY CERTIFY, That I attended deceased from 5/14/, 1930, to 5/15/30, 19...., that I last saw h... alive on 5/15/30, 19...., and that death occurred, on the date stated above, at 10:12 A.m.

The CAUSE OF DEATH* was as follows:

Cardiac Ulcer

(duration) months yrs. mos. ds.

CONTRIBUTORY (Secondary): Ruptured Gastric ulcer & Peritonitis (duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death? Ruptured perforation

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & History

(Signed) Bernard Terry, M. D.

5/15/, 1930 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 19 1930

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 441 Edmondson

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57205 E 57205

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Strauss

(a) RESIDENCE NO. Emerson Apt. 2C WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced (or) WIFE of HUSBAND of Augusta Strauss

DATE OF BIRTH (month, day, and year) May 4 1873

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	0	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Abraham Strauss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosa Adler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Miss M. Strauss

(Address) Emerson Apts.

Filed 6-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 30

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1930, to May 16, 1930, that I last saw him alive on May 16, 1930, and that death occurred, on the date stated above, at 5:35 P. m.

The CAUSE OF DEATH* was as follows:

acute appendecitis with Peritonitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

acute anemia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home 5/11/30

Did an operation precede death? yes Date of 5/12/30

Was there an autopsy? no

What test confirmed diagnosis? Operation.

(Signed) C. Hampson Jones, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Md. Am

DATE OF BURIAL 5/14 1930

20 UNDERTAKER David Sondheim

ADDRESS 1820 W. Mt. Royal Ave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 57206

E 57206

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1031 N Lanvale St. 16-23 WARD)

2-FULL NAME Emma Marie Vey

(a) RESIDENCE No. 1031 N Lanvale St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 8 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 17- 1848

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	8	27 28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Henry P. Vey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louise Hofmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Emil B. Vey

(Address): 1031 N Lanvale

Filed 1930 C. 19 HAMILTON JONES, M. D. Registrar

By RLK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14-30

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 14, 1930, that I last saw h.. alive on May 14, 1930, and that death occurred, on the date stated above, at 2 02 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) ....yrs. ....mos 2 ds.

CONTRIBUTORY (Secondary): Auto cardiac dilatation Sudden

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M Bunman Hood, M. D.

5/A 1930 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bellevue

DATE OF BURIAL: 5/16/30.

20 UNDERTAKER: H. Faulmann & Son

ADDRESS: Hop Pa Av.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57207

E 57207

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Lemnale Belvedere & Greenspring ST. 27-34 WARD

CITY OF BALTIMORE: (No.

2-FULL NAME Anna Felsenfeld

(a) RESIDENCE No. Lemdale, Belvedere & Greenspring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia (State or country)

10 NAME OF FATHER Louis Leib Felsenfeld

11 BIRTHPLACE OF FATHER (city or town) Austria (State or country)

12 MAIDEN NAME OF MOTHER Katie Gettel

13 BIRTHPLACE OF MOTHER (city or town) Austria (State or country)

SIGNATURE ERASED

Informant

(Address)

Filed MAY 16 1930 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-15 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-0-30, 1930, to 5-15, 1930, that I last saw h[illegible] alive on 5-15, 1930, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Chr. valvular heart disease

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Edmund Levin, M. D.

May 15 1930 (Address) Levindale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 5/16 1930

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Balto St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57208

E 57208

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 8815 - 4 1/2 St. Fairfield. St. 25-16 Ward)

2-FULL NAME Carrie Lawson.(C)

(a) RESIDENCE NO. 8815 -4 1/2 St. Fairfield St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
(or) WIFE of Jessie Lawson.(C)

6 DATE OF BIRTH (month, day, and year) December 24, 1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40	4	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) North Caroline.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Cassie Hill.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Caroline.

14 Informant Jessie Lawson.(C) husband.
(Address) 8815 -4 1/2 St. Fairfield.

15 Filed ..., 19... CHAMPION 1930 MAY 16 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Obbendix.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Hemhandl, M. D.

5/18 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvery — DATE OF BURIAL May 17 1930

UNDERTAKER Franklin W Leatz — ADDRESS 709 W 33 St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57209

HEALTH DEPARTMENT—CITY OF BALTIMORE

109-00 E 57209

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Jefferson ST. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Holmes

(a) RESIDENCE NO. 1406 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX F | 4 COLOR OR RACE C | 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Holmes

DATE OF BIRTH (month, day, and year) 1904

AGE Years 26 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Petersburg Va

10 NAME OF FATHER William Stuck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Delphine Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Isaac Holmes

(Address) 1406 Jefferson

Filed ..... 19 ..... C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1 1930 to May 10 1930

that I last saw her alive on May 9 1930

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Phlegmonous Cellulitis

Rheumatic Myocarditis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

5-10. 1930 (Address) 1500 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arbury Cem

DATE OF BURIAL 5/16 1930

ADDRESS Edmondson

20 UNDERTAKER [illegible] Burgess 1631 Edmondson

THE WARD [illegible]

Spec.—1-30—M. & T.—250 Bks

E 57210 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57210

CERTIFICATE OF DEATH.

REGISTERED NO. 119

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No.) Calvert & 33rd ST., 11-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. A Morris Carey

(a) RESIDENCE NO. 100 Cathedral ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. A Morris Carey (MARGARET C. THOMAS)

7 DATE OF BIRTH (month, day, and year) Jan 11th 1861

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	4	3	

8 OCCUPATION OF DECEASED Pres Carey Machine Co

(a) Trade, profession or particular kind of work Pres

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER James Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Rowley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

Informant Hospital Records

(Address)

Filed MAY 16 1930 C. HAMBLETON JENKINS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 14, 1930, that I last saw him alive on May 14, 1930, and that death occurred, on the date stated above, at Daylight Saving 7.30 P. m.

The CAUSE OF DEATH* was as follows: Perforation of sigmoid with abscess

(duration) 4 yrs. 1 mos 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 100 Cathedral St.

Did an operation precede death? Yes Date of 5/9/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William R Faro C., M. D.

May 14, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL May 16th 1930

20 UNDERTAKER Henry H Jenkins Sons

ADDRESS McCulloh & Orchard Sts

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57211

CERTIFICATE OF DEATH.

E 57211

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 4-30 WARD)

2-FULL NAME Flozzie Wallace.

(a) RESIDENCE NO. Lansdowne Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced (or) WIFE of: Harold Wallace

6 DATE OF BIRTH (month, day, and year): Aug 16 1892

7 AGE: Years 37 Months 8 Days 29

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St. Marys County Maryland

PARENTS

10 NAME OF FATHER: Chas M Gatton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Victoria Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Harold Wallace
(Address) Lansdowne Md

15 Filed 1 5 1930 19.... C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-15 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-15 1930 to 5-15 1930

that I last saw h[illegible] alive on 5-15 1930

and that death occurred, on the date stated above, at 3 40 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage. Ettiologic

Placenta Previa. Clinically.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Pregnancy.

(duration) ..... yrs. 9 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/15/30 Prem Placenta

Was there an autopsy? No Clinical.

What test confirmed diagnosis?

(Signed) [signature] M. D.

5-15 1930 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loys Chapel Church Cem St Marys Co Md

DATE OF BURIAL: May 17, 30

20 UNDERTAKER: John Ulrich

ADDRESS: 208 Alex

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57212

CERTIFICATE OF DEATH.

74-001 E 57212

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. STREET 5-8 WARD)

2-FULL NAME Miss Lettie R. Nickle

(a) RESIDENCE NO. 426 Calvin Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1 68

7 AGE — Years: ~~62~~ 62 — Months: 3 — Days: 13 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse, R

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co., Md.

PARENTS

10 NAME OF FATHER Charles Nickle

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Nitta Hurtt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital record
(Address)

15 Filed MAY 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1930

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 14, 1930, that I last saw her alive on May 14, 1930, and that death occurred, on the date stated above, at 2:15 a.m. S.T.

The CAUSE OF DEATH* was as follows:

1 Hypertension, Arteriosclerosis

(duration) 4(?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jno A Hampson Jones M.D.

(Address) 1107 Eutaw Pl

*State the Disease Causing Death, or in deaths from violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Park Cemetery

DATE OF BURIAL May 6 1930

20 UNDERTAKER W M Coulson

ADDRESS 2238 Pitts

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57213 CERTIFICATE OF DEATH. 31 E 57213

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (ST 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Richard Sollers

(a) RESIDENCE NO. 1014 Hillock Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept.17,1887

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	7	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Thomas Sollers

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Kate ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

Informant Hospital Records

(Address)

6 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to May 14, 1930, that I last saw him alive on May 14, 1930, and that death occurred, on the date stated above, at 5 A.M. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D.

5-14, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Zion

DATE OF BURIAL May 17, 1930

ADDRESS

UNDERTAKER Joseph A. Sturdy 1091 Monument St

Filed 1930 By Registrar

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57214 3/ E 57214

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (W.B.G. ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST., WARD)

2-FULL NAME Stanley Daskowitz

(a) RESIDENCE NO. 205 N. Central ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept. 5, 1891

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	8	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant Hospital Records

(Address)

Filed 6 1930 19.. C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1930, to May 12, 1930, that I last saw him alive on May 12, 1930, and that death occurred, on the date stated above, at 7.15 p. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis (duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jos. Hemsley Jr. M. D.

5-13-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery

DATE OF BURIAL 5-16 1930

UNDERTAKER Jack Levin, 1439

ADDRESS E. Balto

Spec.—1-12-23—M&T—500 Blks.

E 57215 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 E 57215

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1919 H Ennerman Ave (WARD) 8-13

2-FULL NAME Jennie Hagans

(a) RESIDENCE NO. 1919 Hennerman Ave, WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Hagans

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

10 NAME OF FATHER Alfred Carnick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Maggie Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

PARENTS

14 Informant Annie Trumblake
(Address) 1919 Hennerman Ave

15 Filed ..... 19 ..... C. H. [illegible] JONES, M. D. Registrar

ID 1330

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 13, 1930, that I last saw h[illegible] alive on 5/13, 1930, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) .. yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) .. yrs. .. mos. .. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Townsley, M. D.

May 15 1930 (Address) 733 Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL 5/17/1930

ADDRESS 1218 Mc Elderry

20 UNDERTAKER Byron Wright

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57216

E 57216

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 322 Kalsom ST. 14-28 WARD)

2—FULL NAME Adolph Bortlee

(a) RESIDENCE NO. 322 Kalsom ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced
(or) WIFE of Mary Boettcher

DATE OF BIRTH (month, day, and year) DEC-[illegible]

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	5	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. Mary Bortlee

(Address) 322 Kalsom

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 30

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1930 to May 14, 1930

that I last saw h[illegible] alive on May 12, 1930

and that death occurred, on the date stated above, at 12 30 m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Hypertension & Dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alfred Adam M. D.

5/16/30 (Address) 1[illegible] Dolphin St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL May 17th 1930

20 UNDERTAKER A. Jones

ADDRESS 11 S. Gilmore

Spec.—1-30—M. & T.—250 Bks.

E 57217

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57217

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 12-19 ST. WARD)

2-FULL NAME Frank McIntyre

(a) RESIDENCE NO. 402 Pinkney Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced (HUSBAND of or) WIFE of Katherine

6 DATE OF BIRTH (month, day, and year) July 1, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 61	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'H O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Peter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine Bannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Records of B. C. H.

(Address)

Filed MAY 16 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-14-30

17 I HEREBY CERTIFY, That I attended deceased from 5-13-30, 19..., to 5-14-30, 19..., that I last saw h. alive on 5-14-30, 19..., and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marcus W. McLean, M. D.

5-15, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL May 19 20

20 UNDERTAKER Mary M Wadsfield

ADDRESS 501 E 22 St

Spec.—2-29-28—L. F. S.—500 Bks.

E 57218 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 57218

14-001

CERTIFICATE OF DEATH

REGISTERED NO. 57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2424 McCulloh St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Annie Smith

(a) RESIDENCE NO. 2424 McCulloh ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female | 4 COLOR OR RACE col | 5 Single, Married, Widowed, or Divorced, (write the word) widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Smith

DATE OF BIRTH (month, day, and year) 4-5-1881

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	1	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Essex Co. Va

10 NAME OF FATHER John Mosby

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Victoria Ritchie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

Informant George Stanley

(Address) 2424 McCulloh

Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-16-30

17 I HEREBY CERTIFY, That I attended deceased from 5-12-30, 19..., to 5-16-30, 19..., that I last saw her alive on 11, 19..., and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) arteriosclerosis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. N. Landing, M. D.

5-16-30 (Address) 1524 O'Neill ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fredericksburg Va

DATE OF BURIAL May 16, 1930

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1722 Ashland ave

THOMPSON-TOWERS, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 57219

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 ✓ E 57219

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 22-31 ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Bond or Barnes

(a) RESIDENCE NO. 731 S. Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of William

6b DATE OF BIRTH (month, day, and year) Oct. 3, 1882?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
47	48 ?	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer .....

BIRTHPLACE (city or town) ..... (State or country) N.Y.

10 NAME OF FATHER John ?

11 BIRTHPLACE OF FATHER (city or town) N.Y. (State or country)

12 MAIDEN NAME OF MOTHER Louisa ?

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) N.Y.

Informant Records of

(Address) Balto. City Hosp.

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-14-30

17 I HEREBY CERTIFY, That I attended deceased from 5-13-30, 19..., to 5-14-30, 19..., that I last saw her alive on 5-14-30, 19..., and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Nephritis, Chronic Diffuse

(duration) ..... yrs. ? mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marion McW McLean, M. D.

5-16, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 5/19, 1930

20 UNDERTAKER Fred A. Krause

ADDRESS 703 Ho

Spec.—1-12-23—M&T—500 Blks.

E 57220

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57220

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Jenkins Memorial Hospital — REGISTERED NO. 90

CITY OF BALTIMORE: (No. 1000 Eutaw Ave ST., 11 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Mitchell

(a) RESIDENCE NO. 1324 Eutaw Place ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Jenkins Memorial Hosp. (Address) 1000 Eutaw Ave

15 Filed MAY 15 19 C. HARRISON JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1930

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1930, to May 14, 1930, that I last saw h[illegible] alive on May 14, 1930, and that death occurred, on the date stated above, at 11-15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brewer M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	May 17 1930
20 UNDERTAKER	ADDRESS
James B Cupp	1324 Eutaw Pla.

Spec.—1-30—M. & T.—250 Bks.

E 57221

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 E 57221

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S. Ann ST., 2-4 WARD)

2-FULL NAME Frank Linig

(a) RESIDENCE NO. 319 S. Ann ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Effie Linig

DATE OF BIRTH (month, day, and year) March 5 1905

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	2	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoeworker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Henry Linig

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Annie Fiel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md

(State or country)

Informant Mrs Linig

(Address) 319 S. Ann St.

Filed 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1930

17 I HEREBY CERTIFY, That I attended deceased from May 3 1930, to May 14 1930, that I last saw h alive on May 14 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman Fleming M. D.

May 15 1930 (Address) 1722 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem.

DATE OF BURIAL May 17 1930

20 UNDERTAKER Lilly & Sons Inc.

ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Bks.

57222

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57222

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST 26-37 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Campbell

(a) RESIDENCE No. 413 Conkling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 weeks ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of -

7 DATE OF BIRTH (month, day, and year) Jan. 1886

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	43	4		

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Crane operator

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

BIRTHPLACE (city or town) Jamestown

(State or country) Va.

10 NAME OF FATHER A. J. Campbell

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Maggie Jefferies

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

Informant Records of

(Address) Balto. City Hosp.

Filed ... C. HAROLD JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-14-30

17 I HEREBY CERTIFY, That I attended deceased from 3-13-30, 19..., to 5-14-30, 19...,

that I last saw him alive on 5-14-30, 19...,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) over 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Inflamed of Lungs

(duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home & here

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Marvin W. McLean, M. D.

5-15, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dana N. Co.

DATE OF BURIAL May 19 1930

UNDERTAKER Lilly & Gilbert Inc.

ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Bks

Emma Kittel ✓

E 57223 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57223

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital 25277 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev Emma Kittel

(a) RESIDENCE No. 3909 Pennington Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Not known

6 DATE OF BIRTH (month, day, and year) Dec 7 1872

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57		5	15	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

8 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Henry Kittel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Eyth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Hospital Record
(Address)

Filed MAY 16 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 1930, to May 15, 1930, that I last saw h[illegible] alive on May 15, 1930, and that death occurred, on the date stated above, at 6:30 p m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab findings

(Signed) Samuel McCracken, M. D.

May 15 1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Lawn Cem Columbus Ohio

DATE OF BURIAL May 19 1930

UNDERTAKER B Lilly & Son Inc

ADDRESS 403 S. High St

Spec—12-23-21—E.B.R.S.—400 Bks.

E 57224

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57224

CERTIFICATE OF DEATH.

47

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 312 Cedarcroft Road St. 21-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Agnes Mercedes Smith Galvin

(a) Residence No. 312 Cedarcroft Road St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, ~~widowed~~, or ~~divorced~~ ~~HUSBAND~~ of (~~or~~) WIFE of John P. Galvin Jr

6-DATE OF BIRTH (month, day and year) January 21, 1894

7-AGE, 36 yrs. 3 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House-wife

(b) General nature of industry, business, or establishment in which employed (or employer). —

(c) Name of employer. —

9-BIRTHPLACE (city or town). Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Florysus C. Smith

11-BIRTHPLACE OF FATHER (city or town). Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Ella Merk

13-BIRTHPLACE OF MOTHER (city or town). Baltimore (State or Country), Maryland

14- (Informant) Helen R. Smith

(Address) 6206 Pinehurst

15- Filed ..... C. HAMPSON JONES, M. D. Registrar.

MAY 16 1930 By R.P.H.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 15, 1930

17- I HEREBY CERTIFY, That I attended deceased from December 7, 1929, to May 15, 1930, that I last saw h.[illegible] alive on May 15, 1930, and that death occurred, on the date stated above, at 4 15 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 2 yrs. 5 mos. 8 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) — yrs. 6 mos. 15 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Thomas K. Galvin M. D.

, 19 (Address) 1129 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL, May 17 1930

UNDERTAKER. Chas. E. Brauer Son

ADDRESS 1181 W. Mt. Royal Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57225

CERTIFICATE OF DEATH.

161 E 57225

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 242 S. Chapel ST., 2nd WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Roberts

(a) RESIDENCE NO. 242 S. Chapel ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

8a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 5-15-30

7 AGE	Years	Months	Days	If LESS than 1 day 10 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Charles Roberts

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Mary Eyorn

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Geo Roberts

(Address) 242 S. Chapel

15 Filed 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-15 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-15, 1930 to 5-15, 1930, that I last saw h[illegible] alive on 5-15, 1930, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos 1/24 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Leo Helgen, M. D.

5-15, 1930 (Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS MAY 16 1930

Per. WT

Spec.—1-10-21—M&T—1500 Bks.

E 57226

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57226

CERTIFICATE OF DEATH.

REGISTERED NO. 1617

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1217 Washington Blvd (St.) 21-72 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Moran

(a) RESIDENCE NO. 1217 Washington Blvd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1930

7 AGE Years Months Days If LESS than 1 day 4 hrs. 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Jos. Thos. Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Emma Janelle Popp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant

(Address)

15 Filed MAY 16 1930 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to May 15, 1930, that I last saw him alive on May 15, 1930, and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH* was as follows:

Premature birth

Congenital atelectasis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clin data

What test confirmed diagnosis?

(Signed) Lashlenger, M. D.

19 (Address) 3034 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS MAY 16 1930

Spec.—1-12-23—M&T—500 Blks.

E 57227

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57227

CERTIFICATE OF DEATH.

112

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 Ashland Ave. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev John S. Rowlett

(a) RESIDENCE NO. 1109 Ashland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Martha Rowlett

6 DATE OF BIRTH (month, day, and year) Sept. 23-1875

7 AGE: 55 (Years / Months / Days)

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: preacher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Neil Rowlett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary A Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Martha Rowlett (wife)

(Address) 1109 Ashland Ave

Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1930

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1930, to May 15, 1930, that I last saw him alive on May 15, 1930, and that death occurred, on the date stated above, at 1:45 P m.

The CAUSE OF DEATH* was as follows:

Gastritis; Acute Hydrogastritis.

(duration) yrs. 1 mos 8 ds.

CONTRIBUTORY (Secondary) Error in Diet

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home of Patient

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Symptoms - Signs

(Signed) H. H. Mosenfelder, M. D.

19 (Address) 1214 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cemetery

DATE OF BURIAL: May 18 1930

UNDERTAKER: Robert J. Mullan

ADDRESS: 1515 N. Eutaw St

8 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57228 5/ E 57228

E 57228

CERTIFICATE OF DEATH

REGISTERED NO. 58-71

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 537 Stamford Road ST., WARD)

2—FULL NAME William H. Garrison

(a) RESIDENCE NO. 537 Stamford Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
M	W.	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Garrison

7 DATE OF BIRTH (month, day, and year) May 2-1872

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of indastry, business, or establishment in which employed (or employer) Republic

(c) Name of employer Radiator Co. Balto Md.

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Wm Garrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Hanna Porter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Husband Wm Garrison

(Address) 537 Stamford Road

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15-1930

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 15, 1930, that I last saw him alive on May 15 1930 and that death occurred, on the date stated above, at 2-25 P. m.

The CAUSE OF DEATH* was as follows:

Acute endocarditis fatal

rheumatic fever.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Embolism Right arm, (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? N Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M Bauman Hood, M. D.

May 16, 1930 (Address) 626 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL May 17th 1930

20 UNDERTAKER Bertram & Son ADDRESS 1723 N Lafayette Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57229

CERTIFICATE OF DEATH

90 E 57229

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2030 Herbert St. Ward) 15-21

2-FULL NAME Sallie E. Crook

(a) RESIDENCE NO. 2030 Herbert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Crook

6 DATE OF BIRTH (month, day and year) Feb 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	70	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Chas Crook
(Address) 2030 Herbert St

15 Filed ..., 19... Registrar ARH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ...
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ... M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys (Hampden Sta	5/17/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Spec.—1-30—M. & T.—250 Blks

E 57230 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57230

CERTIFICATE OF DEATH.

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2043 Edmondson ST., 20-7 WARD

2-FULL NAME Susan Plunkett

(a) RESIDENCE NO. 2043 Edmondson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward J. Plunkett

6 DATE OF BIRTH (month, day, and year): April 23/46

7 AGE: Years 84; Months; Days 22; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER: Joseph R. Mann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Amanda Shore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

Informant: Paul E Plunkett

(Address) 2043 Edmondson

MAY 16 1930 C. HAMPSON JONES, M. D.

Filed ..... 19 ..... Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15-30

17 I HEREBY CERTIFY, That I attended deceased from 5/8, 1930, to 5/15, 1930,

that I last saw h[illegible] alive on 5/15, 1930,

and that death occurred, on the date stated above, at 12 50 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Unknown (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Senility

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Benjamin Rosenthal, M. D.

5/16, 1930 (Address) 1716 E Caloert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: 5/17/1930

20 UNDERTAKER: William Cook

ADDRESS: 1217 St Paul

Spec.—1-10-21—M&T—1500 Blks.

E 57231

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57231

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes, Hospital ST., 25-7 WARD)

2-FULL NAME Mrs Eleanor Key

(a) RESIDENCE No. 1110 Honeyhill Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James G. Key

6 DATE OF BIRTH (month, day, and year): 1892

7 AGE: Years 38 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: James Key

11 BIRTHPLACE OF FATHER (city or town) (State or country): Georgia

12 MAIDEN NAME OF MOTHER: Eleanor Linton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D.C.

14 Informant (Address): [illegible]

15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16th 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-9, 1930, to 5-16, 1930, that I last saw h[illegible] alive on 5-16, 1930, and that death occurred, on the date stated above, at 1[illegible] m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: 5/17/1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 Park Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57232 E 57232

CERTIFICATE OF DEATH

90

REGISTERED NO. 15-60

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2407 Forrest Park Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herbert M. Trappe

(a) RESIDENCE NO. 2407 Forrest Park Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Beulah E. Trappe

DATE OF BIRTH (month, day, and year) July 20, 1886

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	9	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cashier

(b) General nature of industry, business, or establishment in which employed (or employer) 609

(c) Name of employer

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER August F. Trappe

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Pries

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Denmark

Informant Mrs. Beulah E. Trappe

(Address) 2407 ForrestPark Ave.

Filed C. HAMPSON JONES, M. D. Registrar

By

6 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from September 20, 1929, to May 15, 1930,

that I last saw him alive on May 15, 1930

and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Emphysema

Myocarditis — Under Nutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M P Byerly, M. D.

19 (Address) 3048 W. North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Woodlawn Cemetery

DATE OF BURIAL

May 19 1930

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 West Baltimore St.

Spec.—1-12-23—M&T—500 Blks.

Pinnera

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 57233

CERTIFICATE OF DEATH.

74 E 57233

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2807 Eastern Ave. St.) (Ward) 12

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Pinera

(a) RESIDENCE NO. 2807 Eastern Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Rachel Pinera

6 DATE OF BIRTH (month, day, and year) June 13, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
76	75	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Day Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER John Pinera

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Son - 2807 Eastern Ave.

15 Filed: G 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1929, to May 15, 1930.

that I last saw him alive on May 14, 1930

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. 4 mos 19 ds.

CONTRIBUTORY (Secondary) Reno - cardiac

(duration) yrs. 2 mos. 15 ds.

18 Where was disease contracted if not at place of death? in New York -

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Frank R. Di Paula, M. D.

5/15/1930 (Address) 1323 N. Forth Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 5/17/1930

20 UNDERTAKER: Harry A. Wetzke — ADDRESS: Edmondson

Spec.—8-16-29—L. F. S.—100 Bks.

E 57234

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57234

CERTIFICATE OF DEATH

+ 49

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harold D. Conner

(a) RESIDENCE NO. Hagerstown Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. / mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Whit	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) 1914

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
14				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

BIRTHPLACE (city or town) (State or country) Hagerstown Md

10 NAME OF FATHER James L. Conner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hagerstown Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant James L Conner

(Address) Hagerstown Md

Filed 6 1930, 19 ... Registrar

C. HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/16/30

17 I HEREBY CERTIFY, That I attended deceased from 4/21, 1930, to 5/16, 1930

that I last saw h[illegible] alive on 5/16, 1930

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor involving region of 3rd ventricle

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Brain tumor

Carroll College (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/25/30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) George Yeager, M. D.

, 19 (Address) University Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown Md

DATE OF BURIAL May 18 1930

20 UNDERTAKER A R Coffman

ADDRESS Hagerstown

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57235

CERTIFICATE OF DEATH.

100 901 ✓ E 57235

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 515 East St., (St.) 5-8 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul McArthur

(a) RESIDENCE NO. 515 East St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Student

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Sept. 11 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	~~1913~~ Sept.	8-3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student H.S.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Fair Bluff North Carolina

(State or country) Robeson Co.

10 NAME OF FATHER John McArthur

11 BIRTHPLACE OF FATHER (city or town) Robeson Co. N. C.

(State or country)

12 MAIDEN NAME OF MOTHER Sallie Bess

13 BIRTHPLACE OF MOTHER (city or town) Robeson Co. N. C.

(State or country)

PARENTS

Informant John McArthur

(Address) 515 East St.

Filed 6 1930

G. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/14/30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15 1930 to May 14 1930

that I last saw him alive on May 12 1930

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH was as follows:

Chronic Bronchitis

Acute Terminal Bronchopneumonia.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis & Emphysema (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jas. R. Blake, M. D.

5/14/1930 (Address) 924 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Grove

DATE OF BURIAL 5-17 1930

20 UNDERTAKER Jas. M. Skinner

ADDRESS 1625 E. Monument St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57236

CERTIFICATE OF DEATH

164 E 57236

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 26. E. 25th ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie C Unkefer

(a) RESIDENCE NO. 26 E. 25th ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of John E Unkefer

DATE OF BIRTH (month, day, and year) Oct 31st 1847

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	6	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Robert Gorsuch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Ann Angell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Robert A Unkefer

(Address) 26 East 25th Baltimore

Filed 7 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15-1930

17 I HEREBY CERTIFY, That I attended deceased from January 14th, 1930, to May 15, 1930,

that I last saw h alive on May 14th, 1930

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallis W White Jr. M. D.

, 19 (Address) 2801 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Libertytown Md

DATE OF BURIAL May 17th 1930

20 UNDERTAKER Powell & Albaugh

ADDRESS Libertytown Md

Spec.—8-16-29—L. F. S.—100 Blks.

2 2 6 9 2 8 E 57237

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57237

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 21-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarine Bazemore

(a) RESIDENCE NO. 423 W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	B	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) N. Car

10 NAME OF FATHER Milton

11 BIRTHPLACE OF FATHER (city or town) (State or country) N Car

12 MAIDEN NAME OF MOTHER Ella Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N Car

Informant Records

(Address)

Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-15-1930

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 15, 1930, that I last saw h.er alive on May 15, 1930, and that death occurred, on the date stated above, at 9 PM m.

The CAUSE OF DEATH* was as follows:

tuberculous meningitis

Pulmonary tuberculosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? not known.

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? the bacilli found

(Signed) Benjamin C. Baker, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 5/18/30

20 UNDERTAKER Kenneth Hensley

ADDRESS 1078 Madison

Cor.—10-10-29—A Co.—100 Blks.

E 57238

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 E 57238

CERTIFICATE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 18-16 Ward)

2-FULL NAME Anna Williams

(a) RESIDENCE NO. 819 Pebblee Court Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Negro	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant University Hospital
(Address) Balto. Md

C. HAMPSON JONES, M. D.
Registrar

7 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains deserbed above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Burns of legs & arms.
Accidental Death.
Burnt while lighting stove.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 819 Pebblee Court.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edgar Feller, M. D.

5/15. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 5/17 1930

20 UNDERTAKER Bernard H. Stanley

ADDRESS 878 Mad

Spec.—1-30—M. & T.—250 Bks.

E 57239 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 57239

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 17-24 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hynson

(a) RESIDENCE NO. 506 St. Mary ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Elizabeth Hynson

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	3	12 ✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto.

(State or country) Md.

10 NAME OF FATHER Basil Hynson

11 BIRTHPLACE OF FATHER (city or town) Cambridge

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) Cambridge

(State or country) Md.

Informant Records of

(Address) Balto. City Hospitals

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-14-30

17 I HEREBY CERTIFY, That I attended deceased from 5-6-30, 19..., to 5-14-30, 19...,

that I last saw him alive on 5-14-30 4:50 P. M., 19...,

and that death occurred, on the date stated above, at 4:50 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic & acute

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Hypertension: Arteriosclerosis

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

5-16, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 5/17, 19 30

20 UNDERTAKER Samuel K. Stansbury

ADDRESS 598 N. Gilmor

7-1930 C. HAMPSON Jones M. D. Registrar

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 57240

CERTIFICATE OF DEATH

~~E 57240~~ 138

1—PLACE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 10-14 WARD)

2—FULL NAME Ida May Poole

(a) RESIDENCE NO. 1026 N Eden ST., WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Roosevelt

7 DATE OF BIRTH (month, day, and year) July 15-1910

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N.W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga

10 NAME OF FATHER William Griner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Ella Gough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed _____, 19 _____ Registrar

C. HAMPSON JONES, M. D.

T 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-15-1930

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 15, 1930, that I last saw her alive on May 15, 1930 and that death occurred, on the date stated above, at 335 A m.

The CAUSE OF DEATH* was as follows:

Salpingitis, acute, bilateral

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Peritonitis, generalized - 5 days

~~Lobular pneumonia~~ (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 5-12-30

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Howard A Wilson Jr M. D.

5/15, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary cemetery	May 18, 1930
20a UNDERTAKER Mrs. P. H. Elliott	ADDRESS 172 Carlton Ave

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57241 E 57241

74-66

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1811 N. Gay ST., 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Schaefer

(a) RESIDENCE NO. 1811 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 8 mos. 23 da. How long in U. S., if of foreign birth? Life yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Theresa Schaefer

6 DATE OF BIRTH (month, day, and year) Oct. 23 1853

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
76	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

Informant Mrs. Fred. H. Bauernschmidt

(Address) 3506 Batavia Ave

Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19 30, to May 16 19 30, that I last saw h— alive on May 15 19 30, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hugh W. Feldmeyer, M. D.

, 19 (Address) 5703 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL May 19 1930

20 UNDERTAKER Henry Stecher & Sons Inc.

ADDRESS 1301 E Eager St

Spec.—1-30—M. & T.—250 Bks.

E 57242 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57242

CERTIFICATE OF DEATH.

91

REGISTERED NO. 27-56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3330 Woodland Ave ST., WARD)

2-FULL NAME Margaret Burk

(a) RESIDENCE NO. 3330 Woodland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of or) WIFE of Rev. Andrew H. Burk

6 DATE OF BIRTH (month, day, and year) Nov 7th, 1841

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
88	6	8	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) ----------

(c) Name of employer ----------

BIRTHPLACE (city or town) (State or country) Fowbelsburg, Maryland

10 NAME OF FATHER Andrew Burk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER UNKNOWN

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Albert A. Burk

(Address) 3330 Woodland Ave

Filed 7-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May15th, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1929, to May 15, 1930

that I last saw h[illegible] alive on May 15, 1930

and that death occurred, on the date stated above, at 5.30A m.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Bubert M. D.

, 19 (Address) 475 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arcadia, Md. St Paul Cemetery

DATE OF BURIAL May 17, 30

19

20 UNDERTAKER F. B. Wippert-1850 W. Baltimore, St.

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57243 ✓ E 57243

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Eutaw Place. St. 11-21 WARD)

2-FULL NAME Jennie Samuel

(a) RESIDENCE NO. 1209 Eutaw Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of Herman Samuel

6 DATE OF BIRTH (month, day, and year) July 21, 1861.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore. (State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mr. William Samuel

(Address) 1209 Eutaw Place

Filed 7 1930, 19 ... C. THAMPSON JONES, M. ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15th. 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 29, to May 15, 1930,

that I last saw her alive on May 15, 1930,

and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis and myocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) acute dilatation of heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. Frederick Leitz M. D.

May 19 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Har Sinai Cem.

DATE OF BURIAL 5/18/ 1930

UNDERTAKER David Sondheim

ADDRESS 1820 W. Mt. Royal Ave.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57244 129 E 57244

CERTIFICATE OF DEATH

E 57244

REGISTERED NO.

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. South Baltimore General ST., Appleton WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Barbara Frey

(a) RESIDENCE NO. 1 S. Linwood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Frey.

DATE OF BIRTH (month, day, and year) Feb. 23 1861

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	2	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto, Md.

10 NAME OF FATHER Andrew Schuler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Wirdig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Charles Kimpfle

(Address) 1 S. Linwood ave

Filed 7-1930, 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-15-30

17 I HEREBY CERTIFY, That I attended deceased from 4-8, 1930, to 5-15, 1930, that I last saw her alive on 5-15, 1930, and that death occurred, on the date stated above, at 5.25 p. m. S.T.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardio-Renal Vascular Disease (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Physical Signs

What test confirmed diagnosis?

(Signed) Joseph Laukaitis, M. D.

19 (Address) South Baltimore Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL May 19 1930

20 UNDERTAKER George W. Finkler

ADDRESS 1737 E. Eager

Spec—12-23-21—E.B.R.S.—400 Bks.

E 57245

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57245

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 E. Montgomery 12-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Carrie W. Geer

(a) Residence No. 109 E. Montgomery St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, Divorced (write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Dec. 6- 1878

7-AGE. 51 yrs. 5 mos. 9 ds. If LESS than 1 day, ... hrs. or ..... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER. Charles Geer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER. Francis Hardy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14- (Informant) Columbus Hardy

(Address) 109 E. Montgomery

15- Filed 7 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 15, 1930.

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929 to May 15, 1930 that I last saw her alive on May 15, 1930 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 6 yrs. 6 mos. 15 ds.

Exhaustion

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. C. H. Campbell M. D.

5/16, 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery DATE OF BURIAL, May 19 1930

20-UNDERTAKER. Margaret E. Flynn ADDRESS 142 Light St.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57246

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 451 Orchard St. Ward) 11-24

2-FULL NAME Baby Boy Curry

(a) Residence No. 451 Orchard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 161-E 57246

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 11, 1930

7-AGE. yrs. mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None 0 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore, Md. (State or Country)

PARENTS.

10-NAME OF FATHER, John Payne

11-BIRTHPLACE OF FATHER (city or town) Danville, Virginia (State or Country)

12-MAIDEN NAME OF MOTHER, Marie Curry

13-BIRTHPLACE OF MOTHER (city or town) Ringold, Virginia (State or Country)

14- (Informant) Marie Curry

(Address) 451 Orchard St.

15- MAY 7 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-14-30

17- I HEREBY CERTIFY, That I attended deceased from May 11 1930 to May 14 1930

that I last saw h.i.m. alive on May 14 1930

and that death occurred, on ~~the date stated above~~ May 15, at 8.30 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity (30 wks)

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

5/15 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. S. HOPKINS HOSPITAL

DATE OF BURIAL MAY 16 1930

20-UNDERTAKER. Commissioner Health.

ADDRESS

Rep. Wm. E. Woodall

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

VE 57247

55247

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3100 Pinkerton Road ST. 15-58 (WARD)

2-FULL NAME Roza Glazer

(a) RESIDENCE NO. 3100 Pinkerton Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Glazer

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

PARENTS

14 Informant (Address) Sam 1439 E Balto

15 Filed 5 18 1930 C. HAMILTON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 - 30

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 15, 1930, that I last saw h[illegible] alive on May 15, 1930, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis Hypertension Valvular Heart Disease

(duration) 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Phys. Examination

(Signed) Sam Goldberg M. D.

5/17, 1930 (Address) 2210 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Sinai Hebrew Rem

DATE OF BURIAL 5-18-1930

ADDRESS E Balto St.

20 UNDERTAKER Isaac Lewis 1439 E Balto St.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 57248

1—PLACE OF DEATH — REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Marine Hospital ST. 21-29 WARD)

John F. Nelson

2—FULL NAME Joseph Nelson

307 S. Poppleton St.

(a) RESIDENCE NO. 307 Poppelton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Nelson

6 DATE OF BIRTH (month, day, and year) Jan.20, 1872

7 AGE	58 Years	3 Months	28 Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work seaman

(b) General nature of industry, business, or establishment in which employed (or employer) seaman

(c) Name of employer Sch. Levi. Phillips

BIRTHPLACE (city or town) (State or country) Maryalnd

10 NAME OF FATHER James W. Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Hastenings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Records Marine Hospital

(Address)

Filed MAY 18 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb.25, 1930, to May 16, 1930, that I last saw him alive on May 16, 1930 and that death occurred, on the date stated above, at 8:40 p.m.

The CAUSE OF DEATH* was as follows:

Nephritis chronic

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and laboratory

(Signed) Ralph L Platt, M. D.

5/16, 1930 (Address) U.S. Marine Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Crisfield Md

DATE OF BURIAL May 18 1930

UNDERTAKER Geo Block

ADDRESS 1003 West Baltimore St.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57249

CERTIFICATE OF DEATH.

129 E 57249

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3303 Marshall Court WARD 25-75

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Sommerfield

(a) RESIDENCE No. 3303 Marshall Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Sommerfield

6 DATE OF BIRTH (month, day, and year) Apr 16 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coppersmith

(b) General nature of industry, business, or establishment in which employed (or employer) Oil Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Christina Sommerfield

(Address) 3303 Marshall Court

Filed MAY 18 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16/30

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1930, to May 16, 1930, that I last saw him alive on May 16, 1930, and that death occurred, on the date stated above, at 4 AM m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Chronic Nephritis

(duration) yrs. 7 mos — ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Draug. Bleckman, M. D.

, 19 (Address) 2200 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL May 19 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

E 57250 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 46 E 57250

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital S. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma Zeitvogel

(a) RESIDENCE NO. 1615 Walbrook Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter Zeitvogel

6 DATE OF BIRTH (month, day, and year): Nov 6th 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Hungaria

PARENTS

10 NAME OF FATHER: Max Steibel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hungaria

12 MAIDEN NAME OF MOTHER: Annie Eberle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hungaria

14 Informant (Address): Peter Zeitvogel 1615 Walbrook Ave

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/16/30 19

17 I HEREBY CERTIFY, That I attended deceased from 4/15/30, 19, to 5/16/30, 19, that I last saw h[illegible] alive on 5/16/30, 19, and that death occurred, on the date stated above, at 10:10 A.M.

The CAUSE OF DEATH* was as follows:

Empyema thoracicus

(duration) yrs. 1 mos da.

CONTRIBUTORY (Secondary) cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/19/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Hendrix M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: May 19th 1930

20 UNDERTAKER: A. Jones

ADDRESS: 111 S Gilmor

E. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57251

CERTIFICATE OF DEATH.

129 E 57251

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 724 Berry St ST. 13-52 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicklos E. Stinchcum

(a) RESIDENCE NO. 724 Berry St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Stinchcum

6 DATE OF BIRTH (month, day, and year) March 3, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64.	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mrs. Margaret Canty

(Address) 724 Berry St.

Filed ... C. 19 HAMPDEN BAILES, M. D. Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 16, 1930, that I last saw h[illegible] alive on May 16, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis and Nephritis

(duration) ... yrs. 7 mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) J. W. Wilson, M. D.

, 19 (Address) 848 W. 36th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Hampden — DATE OF BURIAL: May 17 19 30

20 UNDERTAKER: Churchill & Son — ADDRESS: 3115 Chestnut

Spec.—1-30—M. & T.—250 Bks. Henry Saiontz

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 57252 — REGISTERED NO. E 57252

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3606 Registertown ST. 15-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Saiontz

(a) RESIDENCE NO. 3606 Registertown Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Saiontz

7 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 45

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant ..... Reine
(Address) 1439 E Baltimore St

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18-1930

17 I HEREBY CERTIFY, That I attended deceased from April, 1929, to May-18-, 1930,

that I last saw him alive on May-18-, 1930,

and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

a General Arterio-selerosis

b Hypertension

(duration) about 7-8 yrs yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. One ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? ordinary Lab. Exam

(Signed) Herman Sandel, M. D.

5/18 1930 (Address) Hermansandel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashur Wash. Road — DATE OF BURIAL May 10- 1930

20 UNDERTAKER Jack Reine, 1439 E Balto St — ADDRESS

JOHNS HOPKINS, M. D.

1 8 1930

Spec.—1-30—M. & T.—250 Bks. Louis Zittrain

6 572'53

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57253 92 E 57253

CERTIFICATE OF DEATH.

REGISTERED NO. 15-58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2909 Boarman Ave., STN. WARD)

2-FULL NAME Louis Zittrain

(a) RESIDENCE NO. 2909 Boarman Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Zittrain

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant, Jr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Leon Zittrain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Jas. F. Lewis

(Address) 1439 E Baltimore St

Filed MAY 18 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17-1930

17 I HEREBY CERTIFY, That I attended deceased from May-17-, 1930, to May-17-, 1930, that I last saw h~~im~~ alive on May-17-, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Coronary occlusion

(duration) yrs. mos ~~ds~~.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Sindel, M. D.

5/18 1930 (Address) 2404 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rest

DATE OF BURIAL 5-18- 1930

20 UNDERTAKER Jas Lewis, 1439 E Balto St

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

E 57254

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57254

CERTIFICATE OF DEATH.

REGISTERED NO. 118

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 9-46 ST., WARD

2-FULL NAME Mrs. Mary Ziegler

(a) RESIDENCE NO. 2323 N. Arlington ave, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Ziegler

6 DATE OF BIRTH (month, day, and year): Feb 1870

7 AGE: Years 60 Months 3 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Joseph Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Heck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Records (Address)

15 Filed 1 8 1930, 19 RLL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/17/30

17 I HEREBY CERTIFY, That I attended deceased from 5/15/30, 19 to 5/17/30, 19, that I last saw her alive on 5/17/30, 19, and that death occurred, on the date stated above, at 6.30 A M.

The CAUSE OF DEATH* was as follows:

Acute Coronary Thrombosis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Leukemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5/15/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Thompson, M. D.

5/17/30 (Address) 1 Mt Vernon Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: May 20 1930

20 UNDERTAKER: Henry Lutz

ADDRESS 1203 N. Broadway

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

123 ✓ E 57255

E 57255

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 East west ST. 23-33 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Edward O'Hara

(a) RESIDENCE NO. 12 East west ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. O'Hara

DATE OF BIRTH (month, day, and year) April 17, 1856

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	0	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Iron Moulder

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Michael O'Hara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Cunard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Eugene O'Hara

(Address) 12 E. West St

C. HAMILTON JONES, M. D.

Filed ..... 19 ..... Registrar

MAY 8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1930 to May 15, 1930

that I last saw h[e] alive on 5.15.30, 19.....

and that death occurred on the date stated above, at 10.18 a m.

Eastern Standard time.

The CAUSE OF DEATH* was as follows: Cholelithiasis. Generalized arteriosclerosis. Myocarditis.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilitation

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) J. Edward Norris, M. D.

5.16, 1930 (Address) 107 East west St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL May 19, 1930

UNDERTAKER Margaret L. Flynn — ADDRESS 1422 Eutaw St.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57256

CERTIFICATE OF DEATH.

161-001 E 57256

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 830 N. Lakewood St., (Ward) 42

2-FULL NAME Delores D. Arnal

(a) RESIDENCE NO. 830 N. Lakewood Ave St., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1. 1930

7 AGE — Years: — Months: — Days: 16 17 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Edward Arnal

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Gladys E Reitler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

Informant (Address): Edward Arnal 830 N. Lakewood Ave

Filed 1 8 1930 19 C. HAMILTON JAMES, M.D. Registrar 12016

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17. 1930

17 I HEREBY CERTIFY, That I attended deceased from May 30 19 30 to May 17 19 30

that I last saw h[illegible] alive on May 17 19 30

and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

1 mo. Pneumonia
Birth
Breech Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred Reitler M. D.

19 21 (Address) 5009 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

20 UNDERTAKER: Wm Cook

DATE OF BURIAL 5/19 19 30

ADDRESS 1217 E Pratt St

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57257 — 90 E 57257

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 James St., 21-29 WARD)

2-FULL NAME Alma E. Kuebler

(a) RESIDENCE NO. 1219 James ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of William F. Kuebler

6 DATE OF BIRTH (month, day, and year) Dec 24 1879

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	50	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Herman J. Stone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Ida M. Naught

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Herman W. Kuebler

(Address) 1219 James St.

Filed MAY 16 1930 C. HOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15/30.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1930, to May 15, 1930, that I last saw h.r alive on May 15, 1930, and that death occurred, on the date stated above, at 9.25 pm.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation.

(duration) — yrs. 6 mos — da.

CONTRIBUTORY (Secondary) none.

(duration) — yrs. — mos. — da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam Etc.

(Signed) C. Thaelton Jones, M. D.

5/17/30 (Address) 888 N Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL May 19, 1930.

20 UNDERTAKER Mr. & Mrs. J. W. Teufel & Son ADDRESS 861 W. Fayette

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57258

CERTIFICATE OF DEATH

8 E 57258

REGISTERED NO. 90-14

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Millionie

(a) RESIDENCE NO. 1003 Greenmount Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) May 11, 1927

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	0	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER James Millionie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Katherine Antonas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

Informant James Millionie

(Address) 1003 Greenmount Ave

Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1930, to May 17, 1930, that I last saw him alive on May 17, 1930 and that death occurred, on the date stated above, at 3 55 a m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Gastroenteritis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron S Tull, M. D.

5/17, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	May 19 1930

20 UNDERTAKER Rita Friedfeld ADDRESS 91 Greenmt Ave

Cor.—10-10-29—A Co.—100 Bks.

E 57259

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 57259

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found on Street

City of Baltimore: (No. Hte 3 Old York Rd St., 9-47 Ward)

2-FULL NAME Daniel January

(a) RESIDENCE NO. 530 Roselle Hill Terrace St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Maria January

6 DATE OF BIRTH (month, day, and year) Mar 29 1849

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	81	1	37	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Federal Res
(b) General nature of industry, business, or establishment in which employed (or employer) Bank
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Daniel January

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Holland

12 MAIDEN NAME OF MOTHER Meyer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Maria January
(Address) 530 Roselle Terrace

15 Filed ....., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Broken down Constitution (duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted — If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. G. Bladel, M. D.

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Presbyterian — DATE OF BURIAL May 19 1930

20 UNDERTAKER Rita Wiedefeld — ADDRESS 914 Greenmount Ave

Spec.—1-30—M. & T.—250 Bks.

E 57260

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 57260

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 Belgian Ave ST. 7-47 WARD)

2-FULL NAME Joseph M. J. Rehm Sr.

(a) RESIDENCE NO. 800 Belgian Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Rehm

DATE OF BIRTH (month, day, and year) Apr 22 1861

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	0	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~None~~

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Michael Rehm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Kath. T. Rehm

(Address) 800 Belgian Ave

Filed MAY 18 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to May 16, 1930,

that I last saw h alive on May 16, 1930;

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis, Chr Nephritis, Mitral & Aortic Insufficiency.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Obliterans

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S. W. Bishop, M. D.

May 17 1930 (Address) 501 Sheridan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Gor. DATE OF BURIAL May 19 1930

20 UNDERTAKER Rita Wiedefeld ADDRESS 114 Grumt Av

Spec.—1-30—M. & T.—250 Bks.

E 57261

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57261

CERTIFICATE OF DEATH.

REGISTERED NO. 36-904

1-PLACE OF DEATH Mercy Hospital ward K 12 ST. 4-25 WARD)

CITY OF BALTIMORE: (No.

2-FULL NAME Mary Hawkins

(a) RESIDENCE NO. 124 W. Pleasant ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of —

7 DATE OF BIRTH (month, day, and year) March 29 1912

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
18	18	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town) md (State or country)

12 MAIDEN NAME OF MOTHER Mabel Henson

13 BIRTHPLACE OF MOTHER (city or town) md (State or country)

Informant Hospital Records (Address)

Filed MAY 18 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/7/1930, 1930, to May 17, 1930, that I last saw her alive on May 17, 1930, and that death occurred, on the date stated above, at 10-10 p. m.

The CAUSE OF DEATH* was as follows:

Renal Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) 0 yrs. 0 mos. 3 da.

18 Where was disease contracted if not at place of death? Unable to State

Did an operation precede death? Nephrectomy yes Date of 5/10/30

Was there an autopsy? no

What test confirmed diagnosis? Cystoscopy

(Signed) Sascha F. Gehighia, M. D.

5/17, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

20 UNDERTAKER David Carter

DATE OF BURIAL 5-18 1930

ADDRESS 916 Pa ave

Spec.—1-10 21—M&T—1500 Bks.

E 57262

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 57262

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1908 Park Ave ST. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa C. McGraw

(a) RESIDENCE NO. 1300 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): William J. McGraw

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE: Years 71; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John E. Haggerty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Eliza Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs. Samuel A. Mortimer 3002 St. Paul St.

15 Filed MAY 18 1930 C. HUDSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 1930

17 I HEREBY CERTIFY, That I attended deceased from October 10, 1929 to May 17, 1930.

that I last saw her alive on May 16, 1930,

and that death occurred, on the date stated above, at 8.30 A.M. Daylight.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

f8 Where was disease contracted if not at place of death? 1300 Aisquith

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Strauss M. D.

5/17, 1930 (Address) 1931 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: May 19, 1930

ADDRESS

16 UNDERTAKER: John O. Mitchell & Sons, 1900 Eutaw Place

Malcolm B. McStatt

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57263

CERTIFICATE OF DEATH.

E 57263

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2202 N. Gilmor St. (WARD) 59

2-FULL NAME Hattie Johnson

(a) RESIDENCE NO. 2202 N. Gilmor ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	M.

6a If married, widowed, or divorced (HUSBAND of) (or) WIFE of John A. Johnson

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Orange Co Va

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant John A Johnson
(Address) 2202 N. Gilmor St

Filed ..... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18/30

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to May 18, 1930,

that I last saw her alive on May 17, 1930,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Tricuspid Insufficiency

(duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary) Parenchymatous and Nephritis, Contracted Liver and Chronic Nausea

(duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

5/18/1930 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL May 20 1930

20 UNDERTAKER Wm. H. Chase Woe — ADDRESS 1400 Madison

To Ice Co $2.00

Spec.—7-17-26—A Co.—200 Bks.

57264

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 57264

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3613 White Ave Ward) 27-43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary Annie Pulley.

(a) RESIDENCE NO. 3613 White Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Lifetime How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 14 — 1848

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	81	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired School teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Wm. Pulley.

11 BIRTHPLACE OF FATHER (City or town) (State or country) Talbot Co. Md.

12 MAIDEN NAME OF MOTHER Harriett Elizabeth Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co Md

14 Informant Mrs Rebecca Bolke (Address) 3613 White Ave

15 Filed MAY 16 1930 C. H. [illegible] JONES Registrar. By RMH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1930 19

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to May 16, 1930, that I last saw h[illegible] alive on May 16, 1930, and that death occurred, on the date stated above, at 11 p. m. standard time

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 3 yr. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Methods

(Signed) George C. Shannon, M. D.

5/17 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

Date of Burial May 19 1930

20 UNDERTAKER [illegible] & Sons Inc

ADDRESS 4 & N Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

E 57265

HEALTH DEPARTMENT—CITY OF BALTIMORE

E-57265

CERTIFICATE OF DEATH

REGISTERED NO. [redacted]

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Hospital for Women of Md. ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Butler Van Wormer

(a) RESIDENCE NO. Troy, N. Y. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	white	Married

6 If married, widowed, or divorced (or) WIFE of Earl H. Van Wormer

DATE OF BIRTH (month, day and year) Sept. 23, 1869

AGE	Years	Months	Days	If LESS than 1 day hrs. min.
60		[illegible]	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Syracuse N. Y.

10 NAME OF FATHER Ebenezer Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pompey N. Y.

12 MAIDEN NAME OF MOTHER Juliett Spencer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pleasant Mount, Penn.

Informant (husband) Earl H Van Wormer

(Address) 13, 101st Troy N. Y.

Filed [illegible] 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1930

17 I HEREBY CERTIFY, That I attended deceased from 1:25 P.M. May 17 1930, to 3:34 A.M. May 18 1930, that I last saw h.e alive on May 18th, 3:33 A.M. 1930 and that death occurred, on the date stated above, at 3:34 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary edema a

auricular fibrillation a

hemiplegia about 24 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary occlusion (duration) 24 hrs. yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John G. Lynn M. D.

May 18 1930 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Syracuse N.Y.

20 UNDERTAKER J. Morken, Son Co

DATE OF BURIAL May 18 1930

ADDRESS Oakland Mc-Callister

Spec.—1-30—M. & T.—250 Blks.

E 57266.

E 57266

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57266

CERTIFICATE OF DEATH.

REGISTERED NO. 100-096

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO. 3-5 ST.) (WARD)

2-FULL NAME Annie Bra Savickas

(a) RESIDENCE NO. 114 Albemarle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Dec. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60 -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework ?

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) ? (State or country) Lithuania

10 NAME OF FATHER Adam Sukwitz ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Reska ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Lithuania

Informant Ocorad ?

(Address) BALTIMORE CITY HOSPITALS

Filed 1-8 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-17-30

17 I HEREBY CERTIFY, That I attended deceased from 6-15, 1929, to 5-17, 1930,

that I last saw h[illegible] alive on 5-17, 1930;

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren McPherson, M. D.

5-18, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 19- 1930
20 UNDERTAKER	ADDRESS
John Grabinowski	423 S. Paca St.

Spec.—8-16-29—L. F. S.—100 Bks.

236750
E 57262

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57267

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward A. Damrich

(a) RESIDENCE NO. Mobile Ala ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18, 1904

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	5	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 66

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ala

10 NAME OF FATHER John J. Damrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary L Fox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ala

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed MAY 19 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-19-1930

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to May 19, 1930, that I last saw him alive on May 19, 1930 and that death occurred, on the date stated above, at 7.32 A m.

The CAUSE OF DEATH* was as follows:

Hemolytic Streptococci Septicemia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Infectious Arthritis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 5.12.30

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) John Hopkins, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mobile, Alabama

DATE OF BURIAL May 19, 1930

20 UNDERTAKER John D. Mitchell & Sons

ADDRESS 1900 Eutaw Place

Spec.—2-29-28—L. F. S.—500 Blks.

E 57268

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74001

E 57268

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 N. Bond ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Schley

(a) RESIDENCE NO. 1520 N. Bond st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? 76 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

If married, widowed, or divorced, HUSBAND of (or WIFE of) Lydia Schley

DATE OF BIRTH (month, day, and year) July 28th 1842

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	9	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Caretaker

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Frederick Schley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs G R. Thompson

(Address) 1520 N. Bond

Filed 9 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18/30

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1930, to May 18, 1930, that I last saw h[illegible] alive on May 17, 1930 and that death occurred, on the date stated above, at 6 15 a. m. last time

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

as stated (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. A. Schutz, M. D.

, 19 (Address) 1107 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U. S. National Cemetery

DATE OF BURIAL May 20th 1930

20 UNDERTAKER George Schilling & Sons

ADDRESS 112 E Monument st

HAMPSON JONES M.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57269

CERTIFICATE OF DEATH

REGISTERED NO. E 57269

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Hospital for Women of Md ST., 15 WARD)

2—FULL NAME Louisa Brogden

(a) RESIDENCE NO. Avon Apts E. Read St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	Married

6 If married, widowed, or divorced [redacted] (or) WIFE of William Brogden

DATE OF BIRTH (month, day, and year) May 11, 1875

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
55			7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Richard Lamey Gettings

11 BIRTHPLACE OF FATHER (city or town) Balto- (State or country) County

12 MAIDEN NAME OF MOTHER Victoria Sellman

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel (State or country) County

Informant Margaret S. Brogden

(Address) 4 Ridgewood Rd. R.F.

Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1930, to May 18 at 11.10 A.M., 1930,

that I last saw h[illegible] alive on May 18 at 11:00 A.M. 1930

and that death occurred, on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Recurrent carcinoma of left breast

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. G. Lynn M. D.

May 18, 1930 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. — DATE OF BURIAL May 20 1930

20 UNDERTAKER H. W. Jenkins Sons Co. — ADDRESS Cathedral & Franklin

MAY 19 1930 C. HAMPSON JONES M.D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57270

CERTIFICATE OF DEATH

57270

REGISTERED NO. 11001

1—PLACE OF DEATH Hospital for Women Gilford ST., 7-1-15 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number)

CITY OF BALTIMORE: (No. Mt. Mary Plath Hall

2—FULL NAME Mrs. Mary Plath Hall

(a) RESIDENCE NO. 218 Pinkneyville Rd. ST., City WARD (Homelessness)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced (or) WIFE of Charles Chauncey Hall

DATE OF BIRTH (month, day and year) June 6, 1903

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	11	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: Walter B. Platt

11 BIRTHPLACE OF FATHER (city or town) (State or country): (Not known) Connecticut

12 MAIDEN NAME OF MOTHER: Mary Perine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore - county

Informant (husband) Charles C. Hall

(Address) 218 Pinkneyville Rd

Filed May 19 1930 HAMPDEN [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1930.

17 I HEREBY CERTIFY, That I attended deceased from 4 P.M. May 13 1930 to 3:25 P.M. May 18 1930, that I last saw h.e alive on May 18 1930 and that death occurred, on the date stated above, at 3:25 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

c cardiac failure following

an attack of la grippe

(duration) 6 days

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Than other members of family had la grippe

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. G. Lynn, M. D.

May 18 1930 (Address) Womens Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: May 20 1930

20 UNDERTAKER: J. Enoch Jenkins & Son Co.

ADDRESS: Eastern Ave & Collington Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57271

CERTIFICATE OF DEATH

45

E 57271

REGISTERED NO.

1—PLACE OF DEATH.

CITY OF BALTIMORE: (No. University Hosp ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Witz

(a) RESIDENCE NO. 739 S. Montford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Witz

7 DATE OF BIRTH (month, day, and year) Dec 25-1853

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	4	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

10 NAME OF FATHER Frederick Kirchbaum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Von Neidenman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Henry Witz

(Address) 3020 Windsor Ave

C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18/30

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1930, to May 18, 1930, that I last saw her alive on May 18, 1930 and that death occurred, on the date stated above, at 3.05 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) M. C. Porterfield, M. D.

5/18, 1930 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	May 21 1930
20 UNDERTAKER George W. Zibler	ADDRESS 1737 E. Eager st

MAY 19 1930

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57272 E 57272

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 Dris Ave St. Evangeline 96-34 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Holston

(a) RESIDENCE NO. 901 Dris Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Holston

DATE OF BIRTH (month, day, and year) Mar 25-1854

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	1	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER John Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Fuchs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant John C. Holston

(Address) 901 Dris Ave

Filed 5 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to May 17, 1930, that I last saw her alive on May 16, 1930, and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro Sclerosis

(duration) Gradual yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tilton, M. D.

5/17, 1930 (Address) 315 S. Highland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL May 20 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Arlington Av

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57273

CERTIFICATE OF DEATH

90 E 57273

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 404 E. Lafayette St. 12-14 Ward)

2-FULL NAME Jesse Lanthorne

(a) RESIDENCE NO. 404 E. Lafayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia

6 DATE OF BIRTH (month, day, and year) March 1 1855

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	75	2	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) 004
(c) Name of employer Va Lanthorne

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Sam Lanthorne

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER — White

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant C. V. Biskle
(Address) 404 E. Lafayette

Filed MAY 19 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. Dis. Heart
Arterio Sclerosis
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. S. Kelly, M. D.

May 19. 1930 (Address) 1634 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL May 21 1930

20 UNDERTAKER Wm Cook 1217 Sh—Pratt ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

E 57274

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 √E 57274

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St. Joseph Hospital St., 8-17 Ward)

2-FULL NAME Philip Walston

(a) RESIDENCE NO. 2047 E. North Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Loretta Walston

6 DATE OF BIRTH (month, day, and year) Jan. 2/1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30	4	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Inspector of
(b) General nature of industry, business, or establishment in which employed (or employer)
(r) Name of employer Gas & Electric Co

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER William Walston.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Carter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Loretta Walston
(Address) 2047 E.North Ave

Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day above.

The CAUSE OF DEATH* was as follows:

Acute Decompensation

Cardio-Renal Disease-Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Serondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. D.

5/17/30 (Address) 503 E.North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 5/20/1930

20 UNDERTAKER Williams Cook

ADDRESS 1207 St. Paul St.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57275

CERTIFICATE OF DEATH

74-001

E 57275

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 S Washington ST.) (4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adam. Derenez

(a) RESIDENCE NO. 514 S Washington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if foreign birth? 78 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) 1852.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work no work old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland.

10 NAME OF FATHER Adam Derenz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

Informant Antoni Derenz son.

(Address) 514 S. Washington st.

Filed JUN 9 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17/30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1930, to May 17, 1930, that I last saw him alive on May 16, 1930 and that death occurred, on the date stated above, at 11 50 A m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? S & S

(Signed) John J Riggs, M. D.

19 (Address) 1627 E Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cemetery

DATE OF BURIAL May 20, 1930

20 UNDERTAKER George A. Weber.

ADDRESS 705 S. Ann st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 57276

E 57276

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 320 S. Eutaw St. 22-30 WARD)

2—FULL NAME Pauline F. Sunesch

(a) RESIDENCE NO. 320 S. Eutaw ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or ~~Divorced, (write the~~ word)
Female	white	widow

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph F. Sunesch

DATE OF BIRTH (month, day, and year) April 15 1847

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	1	1	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in whirh employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town)
(State or country) Germany

10 NAME OF FATHER John Eppley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Hockemeyer

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

Informant Joseph F. Sunesch
(Address) 320 S. Eutaw St.

Filed ..... 19 ..... Registrar

19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1930, to May 13, 1930,
that I last saw her alive on May 13, 1930
and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

..... (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory Findings

(Signed) John A. Buchman, M. D.

, 19 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 19 1930
20 UNDERTAKER for Saenderson & Son	ADDRESS 2173 Penn

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57272

CERTIFICATE OF DEATH.

90 ✓ E 57272

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST. 5-16 WARD)

2-FULL NAME Frank Komastek

(a) RESIDENCE NO. 2233 E Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Mary Komastek ?

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 64 ? | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: Frank Komastek ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hungary

12 MAIDEN NAME OF MOTHER: Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Hungary

Informant: Records of

(Address): BALTIMORE CITY HOSPITALS

Filed 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17. 1930.

17 I HEREBY CERTIFY, That I attended deceased from 5-5, 1930, to 5-17, 1930,

that I last saw him alive on 5-17, 1930,

and that death occurred, on the date stated above, at ? m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Home & Hosp.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harold McC. Law, M. D.

5-18, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Most Holy Redeemer Cem.

DATE OF BURIAL: May 20 1930

20 UNDERTAKER: August Tasek

ADDRESS: 2406 Eastwood ave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57278

90 E 57278

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 916 E. Fayette St. ST. 5-8 WARD)

2-FULL NAME Carl Hued

(a) RESIDENCE NO. 916 E. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) 911

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Asst. Baker

(b) General nature of Industry, business, or establishment in which employed (or employer): 003

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: Henry Hued

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sarah Furdman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

Informant (Address): J. Lewis 1439 E. Balto St.

Filed MAY 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1924, to May 18, 1930, that I last saw him alive on May 18, 1930, and that death occurred, on the date stated above, at 9.30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis —

Aortic - Insufficiency —

(duration) 6 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary - Oedema

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Joseph W. Kelly, M. D.

19 (Address) 1207 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Adath Israel Friendship

DATE OF BURIAL: 5-19-1930

20 UNDERTAKER: Jack Lewis, 1439 E. Balto St.

ADDRESS

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57279

E 57279

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 937 N. Patterson Park Ave. (ST.) (WARD) 12

2-FULL NAME Louis Willem

(a) RESIDENCE NO. 937 N. Patterson Park Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Feb 5 1894

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
36	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 084

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Edward Willem

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Bauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Edward Willem

(Address) 937 N. Patterson Park Ave

Filed ..... 19 H. A. JONES, M. D. Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 16. 30.

17 I HEREBY CERTIFY, That I attended deceased from May 14 = 19 30 to May 16 = 19 30.

that I last saw him alive on May 16 = 19 30,

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis Bed Sores

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 1915

Was there an autopsy? No

What confirmation of diagnosis? Clinical

Signed Wilbur H. Magruder M. D.

5 19 30 (Address) 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County — DATE OF BURIAL May 19, 30

20 UNDERTAKER Geo. E. Miller & Son — ADDRESS 2332 Jefferson

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-007

E 57280 — CERTIFICATE OF DEATH — **E 57280**

REGISTERED NO. 6-70

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 142 N. Kenwood ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine R. Albrecht

(a) RESIDENCE NO. 142 N. Kenwood ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Charles T. Albrecht

DATE OF BIRTH (month, day, and year) 1880 May 1

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50	49	0	15 16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER William Ricker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Margaret Guckert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

Informant Mrs. Charles T. Albrecht

(Address) 142 N. Kenwood ave

Filed MAY 19 1930 HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to May 16, 1930, that I last saw h[illegible] alive on May 16, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Thyroid Dyscrasia.
Acute Cardiac Failure

(duration) — yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Hypertrophy Thyroid

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. N. Meyer, M. D.

5/17, 1930 (Address) 1520 E. 33rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem — DATE OF BURIAL May 20 1930

20 UNDERTAKER Jos. J. Herr — ADDRESS 156 N. Luzerne ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

5/√ E 57281

E 57281

CERTIFICATE OF DEATH

REGISTERED NO. 1010

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 134 N. Rose ST., WARD)

2—FULL NAME William T. Wilkinson

(a) RESIDENCE NO. 134 N. Rose ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word):

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) ~~June~~ Oct. 18/22

AGE: 8 Years | 7 Months | Days | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Balto

10 NAME OF FATHER: William Wilkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Margaret Pugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

Informant: Mrs. Margaret Wilkinson

(Address) 134 N. Rose

Filed ....., 19.... C. HAWKINS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1930, to May 15, 1930, that I last saw h[im] alive on May 17, 1930 and that death occurred, on the date stated above, at 12.30 P.m. E.S.T.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

(duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Lewis, M. D.

5/18, 1930 (Address) 1113 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral [redacted] Ben.

DATE OF BURIAL: May 21 1930

20 UNDERTAKER: Jos L. Sden 156 N. Luzerne

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-601

REGISTERED NO. E 57282

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

7282

1-PLACE OF DEATH
City of Baltimore: (No.) John Hopkins Hospt St. 10-14 (Ward)

2-FULL NAME Mary Smith Britto

(a) RESIDENCE NO. 912 Hellman St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	C.	Maried

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Emanuel Britto

6 DATE OF BIRTH (month, day, and year) Mar 15, 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
59	49	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry William

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Emanuel Britto.
(Address) 912 Hellman St.

15 Filed MAY 19 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? At Hopkins

What test confirmed diagnosis?

(Signed) [signature], M. D.

5/19/30 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary

DATE OF BURIAL May 19, 1930

20 UNDERTAKER Mrs. Ida Snowden

ADDRESS 1708 E. Madison

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57283

CERTIFICATE OF DEATH.

31

E 57283

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. S. ST., 710 WARD)

2-FULL NAME Frank Link

(a) RESIDENCE No. 536 N. Luzerne ave. ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Late Florence Link

DATE OF BIRTH (month, day, and year) Feb. 4, 1873

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	3	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Louis Link

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Hessler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

Informant Hospital Records

(Address)

C. HAMPSON JONES, M.

Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to May 16, 1930, that I last saw him alive on May 16, 1930, and that death occurred, on the date stated above, at 10.05 p. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) ~~One~~ yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Jas Sherwood, M.D.

5-17, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and t2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery — DATE OF BURIAL May 20th 1930

20 UNDERTAKER Lilly & Zeiler Inc — ADDRESS 403 S. Wolfe St

E 57284 500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 57284

CERTIFICATE OF DEATH.

143-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hosp. ST. 7-4 WARD)

2-FULL NAME Edna Piechowiak

(a) RESIDENCE NO. 405 S. Chapel ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Piechowiak

6 DATE OF BIRTH (month, day, and year) Sept. 29th 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
30	31	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Zinkand

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Sophia Sanders

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Sophia Zinkand (mother)
(Address) 405 S Chapel St.

15 Filed 1930 G. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18 19 30

17

I HEREBY CERTIFY, That I attended deceased from 5/17, 19 30, to 5/18, 19 30,

that I last saw her alive on 5/18, 19 30,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Ruptured ectopic pregnancy

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Paralytic ileus

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 5/15/30

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation

(Signed) W. B. Hendrix M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL May 22nd 1930

20 UNDERTAKER Lilly & Zeiler Sol — ADDRESS 4038 Wolfe St

Spec.—1-30—M. & T.—250 Bks.

E 57285

E 57285 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 1

1-PLACE OF DEATH Baltimore City Hospitals (Th) REGISTERED NO.

CITY OF BALTIMORE: (NO. ST., 26 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Graeger

(a) RESIDENCE NO. 416 S. Shaw St. ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret Graeger

DATE OF BIRTH (month, day, and year) 1885

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass moulder

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Graeger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Graeger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Hospital records.

(Address)

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1929, to May 17, 1930,

that I last saw him alive on May 17, 1930,

and that death occurred, on the date stated above, at 9 55 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis and nephritis.

(duration) indefinite period, yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas Glennon Jr., M. D.

5/19, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery — DATE OF BURIAL May 21st 1930

20 UNDERTAKER Lilly & Zeiler Inc — ADDRESS 400 S. Wolfe St

MAY 19 1930 H. Mitchell JONES, M. D.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002

E 57286

E 57286

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 E. 30th ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Infant WOODARD

(a) RESIDENCE NO. 616 E. 30th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of none

7 DATE OF BIRTH (month, day, and year) May 13 '30

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5 hrs	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) infant

(c) Name of employer none

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Thornton Woodard

11 BIRTHPLACE OF FATHER (city or town) Plymouth

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Elizabeth Ruff

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Maryland

Informant Thornton Woodard

(Address) [illegible]

Filed [illegible] 19[illegible] [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 '30

17

I HEREBY CERTIFY. That I attended deceased from May 13, 1930, to May 15, 1930, that I last saw h[illegible] alive on May 17, 1930 and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Eclampsia

Cyanosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. W. Wright, M. D.

5/18/1930 (Address) 1014 E. Lemmon Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 19th 1930
20 UNDERTAKER Lilly + Geiler Inc.	ADDRESS 4038 E. Wolfe St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57287

E 57287

CERTIFICATE OF DEATH

181-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 3915 Hudson St., 26 Ward

2-FULL NAME Otto Yahde

(a) RESIDENCE NO. 3915 Hudson St., 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Yahde

6 DATE OF BIRTH (month, day, and year) Nov 17 1864

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
65	7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer at Bakto.
(b) General nature of industry, business, or establishment in which employed (or employer) Coffee Works.
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Martha Flynn (Daughter)
(Address) 3705 Hudson St.

15 Filed MAY 19 1930 H. [illegible] JONES M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Acc.
Gas Poisoning Ill.
(duration) yrs. mos. da.
CONTRIBUTORY (Secondary) Asphyxia
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What tests confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL May 19 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe St

For

Spec.—8-16-29—L. F. S.—100 Bks.

2B 57288

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 57288

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ollie Ware WEIRS

(a) RESIDENCE NO. 928 Ansquith ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): —

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/7/29

7 AGE — Years: — Months: 9 10 Days: 10 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md—

10 NAME OF FATHER Eddie Ware

11 BIRTHPLACE OF FATHER (city or town) (State or country): U-C—

12 MAIDEN NAME OF MOTHER Rosa Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md—

Informant: Records—

(Address) JOHNS HOPKINS HOSPITAL

Filed 5-19 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17-30

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 17, 1930, that I last saw her alive on May 17, 1930, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia (primary)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Rickets

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. V. Bickford, M. D.

5/17 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvery Cem.

DATE OF BURIAL: 5-19 1930

UNDERTAKER: Byron & Wright

ADDRESS: 1218 N. Eden Berry St

Spec.—8-16-29—L. F. S.—100 Bks.

E 57289

HEALTH DEPARTMENT—CITY OF BALTIMORE

35 ✓

CERTIFICATE OF DEATH

E 57289

1—PLACE OF DEATH U. S. Marine Hospital

CITY OF BALTIMORE: (No. Baltimore, Maryland. ST. 14-70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mathew Forts

(a) RESIDENCE NO. 1401 McCullough St., Balto. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Forts

6 DATE OF BIRTH (month, day, and year) Nov. 10, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work A.B.Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS Somerset

BIRTHPLACE (city or town) Maryland (State or country)

10 NAME OF FATHER Manuel Forts

11 BIRTHPLACE OF FATHER (city or town) Portugal (State or country)

12 MAIDEN NAME OF MOTHER Gilvalzin Silver

13 BIRTHPLACE OF MOTHER (city or town) Portugal (State or country)

Informant U.S. Marine Hospital Records

(Address) Baltimore, Maryland.

Filed ....., 19 HAMP[illegible]NES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to May 16, 1930,

that I last saw him alive on May 16, 1930

and that death occurred, on the date stated above, at 6:00 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of left hip and left sacro iliac joint

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) E. M. Townsend, M. D.

5-17, 1930 (Address) U.S.Marine Hospital, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvery Cem.

DATE OF BURIAL 5-19 1930

20 UNDERTAKER Byron Wright

ADDRESS 1218 Me & Eldery St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

E 57290

CERTIFICATE OF DEATH

E 57290

REGISTERED NO. E 57290

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3612 Elliton Ave ST. 15-61 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward H. Gams

(a) RESIDENCE NO. 3612 Elliton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Belle Galt Gams

7 DATE OF BIRTH (month, day, and year) Aug 3-1858

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71	72	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Stewart & Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Craig Gams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Broom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Mrs. Belle Galt Gams

(Address) 3612 Elliton Ave.

Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17-1930.

17 I HEREBY CERTIFY, That I attended deceased from Mar. 5, 1930, to May 17, 1930, that I last saw him alive on May 17, 1930, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff

(duration) 3 yrs. 13 mos. ds.

CONTRIBUTORY (Secondary) Cystitis & Pyelitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? P. E.

(Signed) Homer L. Todd, M. D.

5/19, 1930 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 20-1930.

20 UNDERTAKER Horace H. Burgee ADDRESS 3231 Falls Road.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57291

CERTIFICATE OF DEATH

E 57291

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~South Robinson~~ Mercy Hospital ST. ~~15~~ WARD)

2-FULL NAME Frank Robinson

(a) RESIDENCE NO 1713 McKean Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	white	mad

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46				

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) Ofc
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Mrs Strohecker

(Address) 216 S. Ebenezer Rd.

Filed 19 1930 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) ~~Not~~ May 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Destruction of Neck.

about 3 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Runner

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) W. J. Rhein, M. D. Coroner

May 20 1930 (Address) 1634 Bucknell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	May 19 1930
20 UNDERTAKER Lilly & Julian Sue	ADDRESS 408 S. Wolfe

c.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57292 ✓ X 49 E 57292

CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland General Hospital 174 REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Akers

(a) RESIDENCE NO. ..... St., ... Ward Rock Hall, Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Akers

6 DATE OF BIRTH (month, day, and year): Aug. 9, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boatman

(b) General nature of industry, business, or estsblishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Harford County Maryland

PARENTS

10 NAME OF FATHER: Isaac Akers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford County, Maryland

12 MAIDEN NAME OF MOTHER: Sarah Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford County, Maryland

14 Informant (Address): Hospitals

15 Filed ..... 19 ..... Registrar: C. HAMPSON JONES, M. D.

MAY 19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/18/1930

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1930, to May 18, 1930, that I last saw h alive on May 18, 1930, and that death occurred, on the date stated above, at 10.05 ST A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of urinary bladder

(duration) yrs. 4 mos 18 ds.

CONTRIBUTORY (Secondary) general metastases

(duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 3/26/30

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) ..... M. D.

19..... (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rock Hall Md. DATE OF BURIAL: May 19 1930

20 UNDERTAKER: Stewart Thomas ADDRESS: Balto

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57293 E 57293

133

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. Calvert & 33rd ST. 27-53 WARD)
(Bermuda Cor Field

2-FULL NAME Mrs. Jules George Fiest

(a) RESIDENCE NO. 5015 Roland Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jules George Fiest

6 DATE OF BIRTH (month, day, and year) May-14-1896

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) [illegible] Md.
(State or country)

10 NAME OF FATHER Charles E Cox

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Frederick Co, Md

12 MAIDEN NAME OF MOTHER Elizabeth Klemfelter

13 BIRTHPLACE OF MOTHER (city or town) York Co. Pa
(State or country)

Informant Deceased
(Address)

Filed MAY 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17/30

17 I HEREBY CERTIFY, That I attended deceased from 5/16/30, 19..., to 5/17/30, 19..., that I last saw her alive on 5/17/30, 19..., and that death occurred, on the date stated above, at 12.25 P m.

The CAUSE OF DEATH* was as follows:

Interstitial cystitis, chronic

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure, acute

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/17/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical course

(Signed) T. C. Thompson, M. D.

5/19, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL May 19, 30

20 UNDERTAKER Steward Mowen Co — ADDRESS Balto

2-29-28—L. F. S.—500 Blks.

E 57294

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 57294

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2121-N-Calvert ST., 12-50 WARD)

2—FULL NAME Adele Smithel

(a) RESIDENCE NO. 2121-N-Calvert ST., 12 WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 10 mos. 18 ds. How long in U. S., if foreign birth 74 yrs. 10 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Single

DATE OF BIRTH (month, day, and year) About July-1-1855

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	74	10	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER George Smithel

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Frances Dorsey

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

Informant Mr. Raymond C. Bryant (nephew)

(Address) 3706 Beech Ave

Filed ..., 19... Registrar ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15-1930

17 I HEREBY CERTIFY, That I attended deceased from May 5-1930, to May 15, 1930,

that I last saw h.. alive on May 14 1930

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis —

(duration) Several — yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis —

(duration) Few yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No — Date of

Was there an autopsy? No —

What test confirmed diagnosis? None —

(Signed) Chas W. Lawrence —, M. D.

May 15, 1930 (Address) 1327 Park Ave —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mikveh Israel DATE OF BURIAL May 20 1930

20 UNDERTAKER Stewart & Monroe ADDRESS Baltimore

HAMDEN JONES M

Spec.—1-12-23—M&T—500 Bks.

E 57295

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57295

CERTIFICATE OF DEATH.

1-29

57295

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1116 Argyle ST. 17-24 WARD)

2-FULL NAME William Gray

(a) RESIDENCE NO. 1116 Argyle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Gray

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE Years 69 Months Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant James H. Gray
(Address) 1116 Argyle Ave

15 Filed May 19 1930 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10 1929 to May 16 1930, that I last saw he alive on May 16 1930, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Indefinite

(duration) Indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

(Signed) Maryland Mitchell, M. D.

(Address) 1534 Druid Hill Ave

May 18, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 5-19 1930

ADDRESS 916

UNDERTAKER Edward Carlson

Do and

Spec.—1-30—M. & T.—250 Bks.

E 57296

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 57296

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals S. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Douglas Richards

(a) RESIDENCE NO. 1529 Orleans St. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Unknown. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1889

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown.

BIRTHPLACE (city or town) Va.
(State or country)

10 NAME OF FATHER Martin Richards

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Johnson

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

Informant Hospital Records.
(Address)

Filed 5 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17/30

17 I HEREBY CERTIFY, That I attended deceased from 2/10/30, 19..., to 5/17/30, 19...,

that I last saw h... alive on 5/17/30, 19...,

and that death occurred, on the date stated above, at 5.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis and diabetes mellitus

(duration) Indefinite period

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Geo Glennon Jr, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL May 21, 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1691 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

E 57297

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57297

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 Eastern ST. 12-30 WARD)

2-FULL NAME Birdie Hayes

(a) RESIDENCE NO. 613 Eastern ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Allie Stayed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucie Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Roy Hayes Brother
(Address) 1432 Ashburton st

15 Filed ....., 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1930

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1930, to May 18, 1930, that I last saw h alive on May 16, 1930, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

accdg to history

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R E Yeakley, M. D.

5/19, 1930 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery DATE OF BURIAL May 21, 1930

20 UNDERTAKER Edward Bryan ADDRESS 1631 Orleans st

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 V

E 57298

CERTIFICATE OF DEATH

E 57298

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 439 N Gilmor St. 16-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Ehler

(a) RESIDENCE NO. 439 N Gilmor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas S Ehler

6 DATE OF BIRTH (month, day, and year) Nov 15 54

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	75	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Stephen Burgess

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Caulk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mattie E Brownell

(Address) 439 N Gilmor

15 Filed MAY 19 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 18 1930

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1930, to May 18, 1930, that I last saw h alive on May 18, 1930, and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 9 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W E Burns, M. D.

5/19 1930 (Address) 616 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — Date of Burial May 20 1930

20 UNDERTAKER W M Rouken — ADDRESS 2238 N Mont

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57299

E 57299

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 576 S Bethel St. 7th Ward)

2-FULL NAME Alex Waskowski

(a) RESIDENCE NO. 576 S Bethel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Malgorzata Wasowska

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	49	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Fertilizer Factory

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Stanislaus Wasowski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Wodarski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Malgorzata Wasowski

(Address) 576 S. Bethel St.

15 Filed ..... 19.....

Registrar

MAY 15 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquisition (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) H. A. Blake, M. D.

19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	5/20 1930
20 UNDERTAKER William Fiaskowski	ADDRESS 1 N Eastern Ave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57300 — CERTIFICATE OF DEATH. — 144 — E 57300

1-PLACE OF DEATH: No. 1 Balto. Genl. Hosp. — REGISTERED NO. 24-33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ..... ST. ..... WARD .....

2-FULL NAME: Laura Kurth

(a) RESIDENCE NO. 130 W Fort Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred: Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced — WIFE of (or) HUSBAND of: John F. Kurth

6 DATE OF BIRTH (month, day, and year): Oct. 24. 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: Walter W. Bayly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Lula Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

Informant: Walter Bayly (Address) 1533 Hanover St

Died: 1-9 1930 — C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/18/30

17 I HEREBY CERTIFY, That I attended deceased from 5/18, 1930, to 5/18, 1930, that I last saw h Ct alive on 5/18, 1930, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Pregnancy

(duration) yrs. 1½ mos ..... ds.

CONTRIBUTORY (Secondary): Placenta Abruptio

(duration) ..... yrs. ..... mos. ¼ ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 5/18/30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Francis V. Fallon, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem

DATE OF BURIAL: May 21 1930

UNDERTAKER: Margaret A. Flynn

ADDRESS: 1422 Light St.

Spec.—1-30—M. & T.—250 Blks.

E 57301 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57301

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Longwood Road ST. 27-53 WARD

2-FULL NAME Sallie Ballard Lucy

(a) RESIDENCE NO. 6 Longwood Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Lucy

DATE OF BIRTH (month, day, and year) Feb. 22, 1850

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	2	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, (State or country) Md.

10 NAME OF FATHER Cyrus Ballard

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER ----

13 BIRTHPLACE OF MOTHER (city or town) --- (State or country)

Informant Mr. Milton W. Lucy

(Address) 6 Longwood Road

FILED MAY 19 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1922, to May 18, 1930, that I last saw her alive on May 17, 1930, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

General Arterio-Sclerosis

chronic interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. Moor, M. D.

, 19 (Address) 516 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: May 20, 1930

UNDERTAKER: John O. Mitchell & Sons, ADDRESS: 1900 Eutaw Pl.

John O. Mitchell & Sons

Spec.—2-29-28—L. F. S.—500 Bks.

E 57302

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57302

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Womans Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 14-30 St., WARD)

2—FULL NAME Mary Josephine Barry

(a) RESIDENCE NO. 1433 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

6 If married, (widowed, or divorced) HUSBAND of (or) WIFE of Daniel Barry (deceased)

7 DATE OF BIRTH (month, day, and year) Oct-20-1863

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	66	5-6	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Thomas J. O'Shaughnessy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Miss Margaret O'Shaughnessy

(Address) 1433 Bolton St.

Filed ....., 19 .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1930

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to May 18, 1930, that I last saw h[illegible] alive on May 18, 1930 and that death occurred, on the date stated above, at 9:25 P m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Carcinoma of Gall Bladder

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of April 21 1930

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Carl P. Clemson, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 5/21 1930

20 UNDERTAKER Henry W. Mears and Son

ADDRESS 605 N. Calvert

Registrar

Spec.—1-30—M. & T.—250 Bks.

E 57303 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57303

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 21-31 ST. WARD)

2-FULL NAME Louisiana Green

(a) RESIDENCE NO. 533 W. West ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1858 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records of (Address) B. C. H.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-11-30

17 I HEREBY CERTIFY, That I attended deceased from 12-17-28, 19..., to 5-11-30, 19...,

that I last saw her alive on 5-11-30, 19...,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Town & here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren M. McLean, M. D.

5-12, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL MAY 19 1930

20 UNDERTAKER C. HAMPSON JONES, M. D. Commissioner Health

ADDRESS

Filed 5-19-30 Registrar

Spec.—8-16-29—L. F. S.—100 Bks.

E 57304

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57304

CERTIFICATE OF DEATH

100-00

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 21-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Knox

(a) RESIDENCE NO. 545 W. West St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O.D.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant

(Address)

Filed MAY 9 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to May 8, 1930, that I last saw him alive on May 8, 1930, and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Diffuse bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical signs

(Signed) W. H. Verney, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Department of Health.

ADDRESS MAY 13 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57305

CERTIFICATE OF DEATH

185

E 57305

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen Hosp, 1928 St., Ward)

2-FULL NAME Catherine Kopp

(a) RESIDENCE NO. 1831 Frederick St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jr Fred Kopp

6 DATE OF BIRTH (month, day, and year) June 13, 1866

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	63	11	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER John Koch

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Young

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Son / Record
(Address)

15 Filed May 19, 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Accidental Fall Fracture Pelvis & Ribs (duration) 2 yrs. 6 mos. 18 da.

18 Where was disease contracted if not at place of death? 1831 Frederick St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) May 17th 1930 F. P. Leith M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 20, 1930

20 UNDERTAKER J. William Offutt

ADDRESS 3516 Old Frederick Road

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57306

CERTIFICATE OF DEATH

177

E 57306

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2330 N. Monroe St. 15-59 Ward)

2-FULL NAME Alfred L. Latimer

(a) RESIDENCE No. 2330 N. Monroe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth M. Latimer

6 DATE OF BIRTH (month, day and year) July 31-1898

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	31	9	17 16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bond Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 66
(c) Name of employer

9 BIRTHPLACE (city or town) N. J.
(State or country)

PARENTS

10 NAME OF FATHER Geo W. Latimer

11 BIRTHPLACE OF FATHER (city or town) N. J.
(State or country)

12 MAIDEN NAME OF MOTHER Alma L. Price

13 BIRTHPLACE OF MOTHER (city or town) N. J.
(State or country)

14 Informant Elizabeth M. Latimer
(Address) 2330 N. Monroe

15 Filed ..... 19 ..... Registrar

9 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident Overdose Paraldehyde Idiosyncrasy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) H. C. Fisk, M. D.

May 17 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	May 20 1930
20 UNDERTAKER	ADDRESS
Wm. C. Black	927 N. Broadway

Spec.—8-16-29—L. F. S.—100 Bks.

E 57307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

E 57307

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1301 St. Paul St. 11-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emily W. Howard

(a) RESIDENCE NO. 1301 St. Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 6 mos. 13 How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of J. Beale Howard

DATE OF BIRTH (month, day, and year) Nov. 6, 1847

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	6	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER James Winchester

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

Informant Arthur C. Howard

(Address) 1301 St. Paul Street

Filed 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-17-30

17

I HEREBY CERTIFY, That I attended deceased from 1928, 19..., to 5-17, 1930,

that I last saw h[illegible] alive on 5-17, 1930

and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS

HYPERTENSION

(duration) 10+ yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) CEREBRAL HEMORRHAGE

(duration) — yrs. — mos. 8 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John F. Dorsey, M. D.

19 (Address) 1129 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park Cemetery

DATE OF BURIAL 5/20 19 30

UNDERTAKER Henry U. Mears and Son

ADDRESS No. 11 Calvert

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57308 ✓ 143 E 57308

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard & Green ST. (or WARD) 30

2-FULL NAME Helen Tucker

(a) RESIDENCE NO. Eastport ~~Md~~ ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) ~~WIFE of~~: Edward Tucker

6 DATE OF BIRTH (month, day, and year): 5/~~24~~ 1905

7 AGE: 25 Years ..... Months ..... Days

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 057

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Annapolis Md

PARENTS

10 NAME OF FATHER: Frank Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country): [illegible]

12 MAIDEN NAME OF MOTHER: Ella Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible] Md

14 Informant: Edward Tucker (Address) Eastport

15 Filed 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/19/30 19

17 I HEREBY CERTIFY, That I attended deceased from 5/18/30, 19, to 5/19/30, 19.

that I last saw her alive on 5/19/30, 19 E.S.T.

and that death occurred, on the date stated above, at 3 PM m.

The CAUSE OF DEATH* was as follows:

Operation shock
Hemorrhage
Peritonitis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary): Extra uterine pregnancy

(duration) ..... yrs. 9 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 5/19/30

Was there an autopsy? No Coroners

What test confirmed diagnosis? Operation & Clinical

(Signed) [illegible] M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Md — DATE OF BURIAL: May 17 1930

20 UNDERTAKER: Charles E. Tucker Sr. — ADDRESS: Annapolis

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57309

E 57309

CERTIFICATE OF DEATH

REGISTERED NO. 44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 7147 Fulton Ave (ST.) 6-27-K (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas B Bond

(a) RESIDENCE NO. 7147 N. Fulton Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX M. | 4 COLOR OR RACE W. | 5 ~~Single, Married,~~ Widowed, or ~~Divorced~~ (write the word) Widowed

If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Nettie Bond

DATE OF BIRTH (month, day, and year) Jan 24 1832

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	98	3	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Gov

(b) General nature of industry, business, or establishment in which employed (or employer) Judge Court

(c) Name of employer Hartford Co

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Thomas B Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant C. Robert Howell

(Address) 7147 Fulton Ave

Filed 9 1930 C. HAMPSON JONES, M. D. Registrar

By ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to May 19, 1930, that I last saw him alive on May 19, 1930 and that death occurred, on the date stated above, at 10 45 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H Bamman M. D.

5/19, 1930 (Address) 626 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cemetery DATE OF BURIAL May 21 1930

20 UNDERTAKER Rettrandt & Love ADDRESS 1323 W Lafayette Ave

Spec.—1-30—M. & T.—250 Bks.

E 57310 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57310

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2105 Belair Road ST. 8-40 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Gillespie

(a) RESIDENCE No. 2105 Belair Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 11 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Rebecca R. (nee Leach)

7 DATE OF BIRTH (month, day, and year): June 5, 1851.

8 AGE: Years 78; Months 11; Days 12; If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

10 BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: Gillespie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

Informant (Address): Mrs. Harry Dundore (Daughter) 2105 Belair Road

Filed 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930, to May 17, 1930, that I last saw him alive on May 17, 1930, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary): Uraemia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Not

(Signed) Jacob Pokorny, M. D.

, 19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 5/20/30

20 UNDERTAKER: Harry H. Weitzke, 4101 Edmondson Ave. — ADDRESS

Spec.—1-12-23—M&T—500 Bks.

E 57311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 57311

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General ST., WARD

2-FULL NAME Mrs Rosalie Marchese

(a) RESIDENCE NO. 3224 Gwynns Falls Pkwy ST., WARD

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Ignazio~~ Marchese

6 DATE OF BIRTH (month, day, and year) Sept. 25, 1875

7 AGE Years	Months	Days	If LESS than 1 day hrs or min.
54	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Gragonio Costa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Filamena Cancemi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Frank Della Rocca

(Address) 3224 Gwynns Falls

15 Filed 5-21, 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1930

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to May 19, 1930, that I last saw h[illegible] alive on May 19, 1930 and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis c

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Athens

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory

(Signed) J. V. Cadogna, M. D.

, 19 (Address) W. Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 5/21/30 19

20 UNDERTAKER Mary T. Tuth Jr

ADDRESS 1735 Hanover

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57312

CERTIFICATE OF DEATH

E 57312

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Viola Penta

(a) RESIDENCE NO. 924 N. Eugene ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7/7/1924

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	10	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

BIRTHPLACE (city or town) Balto (State or country) Md

10 NAME OF FATHER Wm. Penta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rose Franchetta

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

Informant Wm. Penta

(Address) 924 N. Eugene St

Filed 9 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18/30

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1930, to May 18, 1930, that I last saw h alive on May 18, 1930 and that death occurred, on the date stated above, at 3:20 A m.

The CAUSE OF DEATH* was as follows:

Appendicitis Suppurative

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/16/30

Was there an autopsy? No

What test confirmed diagnosis? History. P.E. clinical symptoms, Operation,

(Signed) H. Glenn Speicher M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL 5/19/30

20 UNDERTAKER Mary T. Ruth

ADDRESS 1235 Hanford

Spec.—1-30—M. & T.—250 Bks.

E 57313

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57313

CERTIFICATE OF DEATH.

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (No.) C. (ST.) 15-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: William Bald

(a) RESIDENCE NO. 1522 McKean Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred: life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced: (HUSBAND of or) WIFE of Susan J. Bald ~~Unknown~~

7 DATE OF BIRTH (month, day, and year) Nov. 11, 1849

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	6	7	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): U.S.

10 NAME OF FATHER: Frederick Bald

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christine Riteas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

Informant: Records of

(Address): B. C. H.

Filed ... H. C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-18-30

17 I HEREBY CERTIFY, That I attended deceased from 7-1-29, 19..., to 5-18-30, 19...,

that I last saw him alive on 5-18-30, 19...,

and that death occurred, on the date stated above, at 8:10 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin F. McKean, M. D.

5-19, 1930 (Address) Balto. City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: May 20, 1930

UNDERTAKER: Wm J. Tuckers Sons

ADDRESS: N. & Pa.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57314

CERTIFICATE OF DEATH

E 57314

REGISTERED NO. 27-45

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Bernard Keenan

(a) RESIDENCE NO. 416 Winston Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) March 30, 1925

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	5	1	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Melrose, Mass.

10 NAME OF FATHER Bernard F Keenan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila, Pa.

12 MAIDEN NAME OF MOTHER Katharine Pickles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston, Mass

Informant Mrs. Bernard Keenan

(Address) 416 Winston Ave

Filed MAY 20 1930 JAMES W. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1930

17

I HEREBY CERTIFY, That I attended deceased from April 23, 1930, to May 18, 1930, that I last saw him alive on May 18, 1930 and that death occurred, on the date stated above, at 8 55 P m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 31 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Mastoid Date of May 13, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Myron G. Tull, M. D.

5/19, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 20 1930
20 UNDERTAKER Wm J Tuckner & Sons	ADDRESS N. A. Pa.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57315

CERTIFICATE OF DEATH

31 ✓

E 57315

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 215 Arlington Ave ST. WARD

2—FULL NAME Wm Tyler

(a) RESIDENCE NO. 215 Arlington Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	married

6 If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Jeannette Tyler

DATE OF BIRTH (month, day, and year) Unknown 1886

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER John Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Sarah Dent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

Informant Jeannette Tyler

(Address) 215 Arlington Ave

Filed ....., 19.... Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17/30

17 I HEREBY CERTIFY, That I attended deceased from Mar. 28, 1930, to May 17, 1930

that I last saw him alive on May 17, 1930

and that death occurred, on the date stated above, at 9.05 P.M. (D.S.T.)

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) David E. Wagner, M. D.

5/19, 1930 (Address) 1006 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Port. Cemetery	May 20 1930
20 UNDERTAKER John H. Toadvine	ADDRESS 1027 Arlington Ave

Spec.—1-30—M. & T.—250 Pks.

E 57316 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

34 E 57316

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. 22-31 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Bell

(a) RESIDENCE NO 811 Peach Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothy Bell

6 DATE OF BIRTH (month, day, and year) Oct. 5-1905

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	7	12	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Andrew Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elverta Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Record

(Address)

15 Filed ... 1930 H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-17-30

17 I HEREBY CERTIFY, That I attended deceased from 5-8, 1930, to 5-17, 1930, that I last saw h[illegible] alive on 5-17, 1930, and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Pott's disease Last Lumbar and first Lumbar vertebra.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Dumpkins, M. D.

(Address) Balto. City Hosp. 5-17, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn et — DATE OF BURIAL May 20 1930

20 UNDERTAKER S. L. Brown & Son — ADDRESS 108 W. Monroe St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57317 3/E 57317

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 7-12

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Woodley

(a) RESIDENCE NO. 1024 N. Durham st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1878

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	51			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER Henry Woodley

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mirah Palen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

Informant Hospital Records
(Address)

Filed 6-1930. 19 ..... C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1928, to May 17, 1930,

that I last saw him alive on May 17, 1930,

and that death occurred, on the date stated above, at 2.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) indefinite period. yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M.D.

5-17 1930 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem.

DATE OF BURIAL 5-20 1930

20 UNDERTAKER Byron & Wright 1218 N Eldersley

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 57318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 57318

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 845 Woodward ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Georgianna Beck

(a) RESIDENCE NO. 845 Woodward ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Beck

DATE OF BIRTH (month, day, and year) Oct. 4, 1879

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	7	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER William H. Keenan

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Anna Clements

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

Informant Mr. Frederick Beck

(Address) 845 Woodward St.

Filed MAY 20 1930 HAM[illegible] JOURS M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930 to May 18, 1930

that I last saw her alive on May 15 1930, 1930

and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Urine analysis & Blood Poisons

(Signed) Hans Zinsser, M. D.

5/19, 1930 (Address) 523 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: May 22 1930

20 UNDERTAKER: Ella B. Cook

ADDRESS: 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57319

E 57319

CERTIFICATE OF DEATH

REGISTERED NO. 86 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secours Hospital (WARD)

2—FULL NAME Ada E. Slacum

(a) RESIDENCE NO. 107 Scott ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. ds. · How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 24, 1927

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	4	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Clyde Slacum

11 BIRTHPLACE OF FATHER (city or town) Golden Hill
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Hazel Wallace

13 BIRTHPLACE OF MOTHER (city or town) Fishing Creek
(State or country) Maryland

Informant Mr. Clyde Slacum
(Address) 107 Scott St.

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18/30

17 I HEREBY CERTIFY, That I attended deceased from 5/13, 1930, to 5/18, 1930

that I last saw her alive on 5/17, 1930

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Empyema thoracis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/15/30

Was there an autopsy? No

What test confirmed diagnosis? Operation & exam

(Signed) Thos. E. Stacy, Jr., M. D.

5/18, 1930 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: May 20 1930

20 UNDERTAKER: J. S. Block — ADDRESS: 1003 West Baltimore St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57320

E 57320

CERTIFICATE OF DEATH.

118-602

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Bon Secour Hospital St. 20-27 Ward)

2-FULL NAME William Sylvester Stricker

(a) RESIDENCE NO. 1826 W. Fairmount Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred. Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen A. Stricker

6 DATE OF BIRTH (month, day, and year) May 31, 1886

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	43	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper 13

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. and O. R. R.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Francis A. Stricker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore County Maryland

12 MAIDEN NAME OF MOTHER Sarah Turner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Montgomery County Maryland

14 Informant Mrs. Helen A. Stricker

(Address) 1826 W. Fairmount Ave.

15 Filed 2 07 1930 19 RLM Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. 1 ds.

May 19/30 (Signed) J. C. Slade M. D.

(Coroner)

19 (Address) 143 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

Date of Burial May 22 19 30

20 UNDERTAKER J. A. Cook

ADDRESS 1003 West Baltimore St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57321 E 57321

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2514 E Federal ST., 8-16 WARD)

2-FULL NAME Lillie Pennington

(a) RESIDENCE No. 2514 E Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married.

6a If married, widowed, or divorced HUSBAND of or) WIFE of Wm. E Pennington

6 DATE OF BIRTH (month, day, and year) May 20 1870

7 AGE: Years 59 | Months 11 | Days 28 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer at home

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John N Norfolk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elmira Wooden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Wm E Pennington

(Address) 2514 E Federal St

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug ..., 1929 ..., to May 18 ..., 1930 ...,

that I last saw h.. alive on May 17 ..., 1930 ...,

and that death occurred, on the date stated above, at 355P m.

The CAUSE OF DEATH* was as follows:

Mitral Murmur, Tuma on R. low abdomen & General Anasarca

(duration) 2 yrs. ? mos ds.

CONTRIBUTORY (Secondary) Mitral Murmur & Abdominal Tuma (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2514 Federal St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. J. Carman, M. D.

5 18 1930 (Address) 1701 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery | DATE OF BURIAL: 5-21 1930

20 UNDERTAKER: E & B Harle 1156 W Fay St | ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 57322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

E 57322

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1936 Mt Royal Terrace ST., 19-20 WARD)

2-FULL NAME Matilda Carlson

(a) RESIDENCE NO. 1936 Mt Royal Ter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 6, 1855

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	74	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer Mrs A Jon Kjellman

BIRTHPLACE (city or town) Sweeden
(State or country)

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Sweeden

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Sweeden

Informant A Jon Kjellman
(Address) 1936 Mt Royal Ter

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 2nd, 1930, to May 18th, 1930,

that I last saw her alive on May 18th, 1930,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis with acute dilitation

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Personal observation

(Signed) Wm Conrad Dade, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 5/21/1930

20 UNDERTAKER William Cook

ADDRESS 1217 E Baltimore St

Cor.—10-10-29—A Co.—100 Bks.

Dr Mowbray

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 57323

57323

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3461 Hickory Ave 13-52 St., W—)

2-FULL NAME Henry N. Bailey

(a) RESIDENCE NO. 3461 Hickory St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Ellen M.

6 DATE OF BIRTH (month, day, and year) Sept 3-1853

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	76	8	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brass Finisher
(b) General nature of industry, business, or establishment in which employed (or employer) Mt. Steamer 010
(c) Name of employer Bell Company

9 BIRTHPLACE (city or town) Philadelphia
(State or country)

PARENTS

10 NAME OF FATHER Edwin Bailey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Ellen M. Bailey
(Address) 3461 Hickory Ave

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular
Disease of Heart

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Earl Mowbray, M. D.

5/19 1930 (Address) 7622 Bellona Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 5/21/1930

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul

Spec.—1-12-23—M&T—500 Bks.

E 57324

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57324

CERTIFICATE OF DEATH

1-PLACE OF DEATH Jenkins Memorial Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1000 Caton Ave ST., (Ward) 27th

2-FULL NAME William H. Hooper

(a) RESIDENCE NO. 6100 Eversall Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) May 30th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk, Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Mechanical Dept

(c) Name of employer B. & O. R. R.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm H. Hooper

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha A. Hodges

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Maryland

14 Informant Jenkins Memorial Hospital

(Address) 1000 Caton Ave

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 19 30

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 19 29, to May 18, 19 30,

that I last saw him alive on May 18, 19 30,

and that death occurred, on the date stated above, at 1-55 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) Ernest Spencer Jr., M. D.

, 19 (Address) St agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 22nd 30

UNDERTAKER Frederick Lassahn Sons Fullerton

ADDRESS

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57325
Ped.

CERTIFICATE OF DEATH

118-002

E 57325

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 4-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gordon Oglesby

(a) RESIDENCE NO. 2611 Boone ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	—

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 4/6/30

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	12 days.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto.
(State or country) Md.

10 NAME OF FATHER Bertram Oglesby

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mazelle Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

FILED 20 1930 HAROLD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-18-30

17

I HEREBY CERTIFY, That I attended deceased from 4-16, 1930, to 5-18-30, 19..., that I last saw h... alive on 5-18-30, 19..., and that death occurred, on the date stated above, at 5-5 a. m.

The CAUSE OF DEATH* was as follows:

congenital atresia of duodenum
intestinal obstruction.

(duration) Life yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5-10-30

Was there an autopsy? yes

What test confirmed diagnosis? operation

(Signed) E V Bradford, M. D.

5/18. 1930 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

UNDERTAKER Wm. R. Elliott

DATE OF BURIAL May 20, 1930

ADDRESS 1927 Ashland Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57326

CERTIFICATE OF DEATH.

11 ✓ E 57326

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 7-13 WARD)

2-FULL NAME Frank J. Rebak (Smith)

(a) RESIDENCE NO. 912 So. Castle St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 40 — Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: City

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Rebak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Mary Matyas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant (Address): John Rebak 912 So. Castle St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/18/30 19

17 I HEREBY CERTIFY, That I attended deceased from 5/11/30, 19..., to 5/18/30, 19...

that I last saw h[illegible]live on 5/18/30, 19...,

and that death occurred, on the date stated above, at 5.35 A. m.

The CAUSE OF DEATH* was as follows:

acute appendicitis and Peritonitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/12/30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M. B. Hendrix, M. D.

, 19 (Address) St. Jo. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: May 21 1930

20 UNDERTAKER: Frank Grad Son 1906 — ADDRESS: Eastlake

C. HAMILTON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57327

CERTIFICATE OF DEATH.

129 ✓ E 57327

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N Fulton Ave St. 20-37 Ward)

2-FULL NAME Miss Elizabeth Wilson

(a) RESIDENCE NO. Home for the aged of the M. E. Church Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life times How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) July 17 1858

7 AGE: Years 71 | Months 9 | Days 7 | IF LESS than 1 day ✓ hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER James Wilson

11 BIRTHPLACE OF FATHER (city or town): Philadelphia

(State or country): Penna

12 MAIDEN NAME OF MOTHER Elizabeth Aler

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Md

14 Informant: Etta Cuddy

(Address): 400 N. Fulton Ave.

15 Filed ..., 19... RLK. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 19 1930

17

I HEREBY CERTIFY, That I attended deceased from Apr 18, 1930, to May 19, 1930, that I last saw her alive on May 16th, 1930, and that death occurred, on the date stated above, at 7.20 a.m. standard time

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ✓ yrs. 3 mos. ✓ ds.

CONTRIBUTORY (Secondary) Nephritis chronic

(duration) 3 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) Geo. C. Shannon, M. D.

5/19 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial May 21 1930

20 UNDERTAKER: George J. Smith ADDRESS 153 Holbert

Spec.—8-16-29—L. F. S.—100 Bks.

E 57328 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57328

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST. H-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Price

(a) RESIDENCE NO. Toronto, Canada ST., WARD

(If non-resident give City or Town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unk

7 DATE OF BIRTH (month, day, and year) 1889

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
51	41			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 008

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unk

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk

Informant Hospital Record

(Address)

Filed 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from May, 16, 1930, to May 18, 1930, that I last saw h[illegible] alive on May, 18, 1930 and that death occurred, on the date stated above, at 6.45 p m.

The CAUSE OF DEATH* was as follows:

1 Hernia - Inguinal Strangulated for 4 days

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May, 16, 1930

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. C. Porter Seed, M. D.

May 18, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Toronto, Canada

DATE OF BURIAL 5/20 1930

ADDRESS 640 S Stiles

UNDERTAKER Leonard C. Peck

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57329

CERTIFICATE OF DEATH.

129 E 57329

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1006 Fayette ST. 18-16 WARD)

2-FULL NAME Mary Griggs

(a) RESIDENCE NO. 1006 Fayette ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (~~Husband of~~ or) WIFE of: Ambrose Griggs

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: 70 | Months: — | Days: — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Atlanta Ga

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Atlanta Ga

14 Informant (Address): Joshua Griggs 1006 W Fayette St

15 Filed 2 0 1930 RPG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1930

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1930, to May 18, 1930 that I last saw her alive on May 18, 1930 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH was as follows:

Chronic Nephritis

Myocarditis

(duration) ~~yrs.~~ ~~mos.~~ 6 ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. F. Howell, M. D.

5/19 1930 (Address) 601 N Carrollton Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: May 20, 1930

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 322 N Schroeder St

Cor.—10-10-29—A Co.—100 Bks.

E 57330

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

78 E 57330

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Light & Cross Sts. St. 23-31 Ward)
(Mary)

2-FULL NAME Mamie Grace Reed.

(a) RESIDENCE NO. 1117 Peach Alley. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 0 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~
~~HUSBAND of~~
(or) WIFE of George W. Reed.

6 DATE OF BIRTH (month, day, and year) April 27, 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	86	0	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles J. Clayton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Annie Eyruth.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Annie Clayton. (mother)
(Address) 1117 Peach Alley.

15 Filed 20 1930 16 [illegible] M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy.

Acute dilatation of the heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No. Inquiry

What test confirmed diagnosis?

(Signed) Otto M. Reinhardt, M. D.

5/19, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. Cem.

DATE OF BURIAL 5/22/30.

20 UNDERTAKER [illegible]

ADDRESS 127 N. Paca St.

Spec.—1-30—M. & T.—250 Bks

E 57331 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57331

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 3114 Clearview Ave Shadow Lawn REGISTERED NO. 27-48
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD)

2-FULL NAME James Henry Walsh

(a) RESIDENCE NO. 3114 Clearview Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Emma

7 DATE OF BIRTH (month, day, and year) Aug 5 1883

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	9	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Peter Vernon Chicago

9 BIRTHPLACE (city or town) Chicago Ill
(State or country)

10 NAME OF FATHER Patrick Walsh

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

Informant Mrs Emma Walsh
(Address) 3114 Clearview

Filed ..... 19 C. HARRY JONES, M. D.
Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 20 - 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/29, 1929, to May 20, 1930, that I last saw h. alive on Sunday, 1930, and that death occurred, on the date stated above, at 8 45 a. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Bladder

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Chicago

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopy

(Signed) Walter J. Klemm M. D.

, 19 (Address) 4100 N. Clark

*State the Disease Causing Death, or in deaths from Violent Causes, state (i) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chicago Ill

DATE OF BURIAL 5/20 1930

ADDRESS 1217 St Paul

UNDERTAKER Wilson Croc

Spec.—1-30—M. & T.—250 Bks.

E 57332 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 ✓ E 57332

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Balto City Hospls

CITY OF BALTIMORE: (No. Balto Md ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Booze

(a) RESIDENCE NO. 1120 Linden Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of William Booze

DATE OF BIRTH (month, day, and year) 1896

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
34				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

BIRTHPLACE (City or town) (State or country) N. Carolina

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records City Hosp

(Address) Balto City Hosp

Filed JUN 20 1930 HAMPSON GATES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-18-30

17 I HEREBY CERTIFY, That I attended deceased from 6-5-, 1928 to 5-18, 1930

that I last saw her alive on 5-17-, 1930

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Psychosis & Mental Deficiency

Pulmonary Tbc (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

5/19 1930 (Signed) Harry F. Adams, M.D.

(Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 5/20/ 1930

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1631 Druid Hill Ave

Spec.—1-30—M. & T.—250 Bks.

57333

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 57333

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto City Hosp. ST 76-1 WARD)

CITY OF BALTIMORE: (No.....

2-FULL NAME Geo. W. King

(a) RESIDENCE NO. 3302 Hudson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

7 DATE OF BIRTH (month, day, and year) July 9 - 1854

8 AGE: 75 Years 10 Months 11 Days 9 If LESS than 1 day, ... hrs. or ..... min.

78 - 75

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) — 08

(c) Name of employer —

BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER John King

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Md.

Informant Hosp. Record.
(Address) Baltimore City Hosp.

Filed MAY 26 1930 JAMES H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 - 1930

17 I HEREBY CERTIFY, That I attended deceased from 3 - 1, 1930, to 5 - 18, 1930,

that I last saw him alive on 5 - 18, 1930,

and that death occurred, on the date stated above, at 11 45/4 m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Fred M. Dunkenfield, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charlestown Cecil Co Cem — DATE OF BURIAL: May 21 1930

20 UNDERTAKER: Chas C. Miller & Son 2334 Jeffers — ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57334

CERTIFICATE OF DEATH

74-001

E 57334

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 614 W Hoffman St., 7-24 Ward

2-FULL NAME Lillie L Green

(a) RESIDENCE NO. 614 W Hoffman Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no.

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE: Years 42 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid
(b) General nature of industry, business, or establishment in which employed (or employer): do
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Wm Williams

11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)

12 MAIDEN NAME OF MOTHER: Minnie Curry

13 BIRTHPLACE OF MOTHER (city or town): Md
(State or country)

14 Informant: Frances Green
(Address): 614 W Hoffman St

15 Filed ..... 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Sudden
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Necessity

(Signed) [illegible] Kirk, M. D.

(Address) [illegible] Gordon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 5 21 1930

20 UNDERTAKER: Sears Easton

ADDRESS 816

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57335

E 57335

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital Ward)

2-FULL NAME Nannie Long

(a) RESIDENCE NO. 180 New Pittsburg Ave St., Ward Balto Co Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. A. Long

6 DATE OF BIRTH (month, day, and year) 2/18/1875.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	55	3	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Alexander Seward

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah J. Wheatley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Thomas A. Long
(Address) 247 S. Conkling St.

15 Filed 1930 By C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 19 1930

17 I HEREBY CERTIFY That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Tilley, M. D.

5/20 1930. (Address) 2739 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL May 20 1930

20 UNDERTAKER John Ellrich

ADDRESS 2008 Aliceanna

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57336

CERTIFICATE OF DEATH

E 57336

REGISTERED NO. 27-42

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4102 Idaho Ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Isse

(a) RESIDENCE NO. 4102 Idaho ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

If married, widowed, or divorced (or) WIFE of May Crouch Isse

DATE OF BIRTH (month, day, and year) June 17-1886

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	43	11	1	

OCCUPATION OF DECEASED Carpenter. War Veteran

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 615

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Butte Mont

10 NAME OF FATHER John Isse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Piemeisel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs Eliz. Loggner

(Address) 4102 Idaho Ave

C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1928, to May 18, 1930, that I last saw him alive on May 17, 1930, and that death occurred, on the date stated above, at 1160 A m. E.S.

The CAUSE OF DEATH* was as follows:

Pulmonary Intercutose

(duration) 10 yrs. mos. ds.

Exhaustion following Hemorrhage

CONTRIBUTORY (Secondary) (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Goss, M. D.

5/18, 1930 (Address) 413 N. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL May 21, 1930

20 UNDERTAKER John Ulrich

ADDRESS 2006 Orleans

Spec.—1-30—M. & T.—250 Bks.

E 57337

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57337

100-006

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1742 Bank St, St. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Rarick

(a) RESIDENCE NO. 1742 Bank St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Rarick

7 DATE OF BIRTH (month, day, and year) Mar 7 1836

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84.	2	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER James B. Douglass

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sr. Talitha Scarf

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

Informant (Address) Mrs. Mamie Rarick 1742 Bank St

Filed JUN 1930 C. HAMPSON JONES, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1930

17 I HEREBY CERTIFY, That I attended deceased from May 5 1930, to May 19 1930, that I last saw h... alive on May 18 1930, and that death occurred, on the date stated above, at ... a.m.

The CAUSE OF DEATH* was as follows: Senile Bronchopneumonia

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) General Contributory

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Frank A. Fraser, M. D.

, 19 (Address) 125 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL May 22 1930

20 UNDERTAKER Israel Lyter — ADDRESS Woodlawn

Spec.—1-30—M. & T.—250 Bks.

E 57338

E 57338 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1605 E Chase ST. 7-13 WARD)

2-FULL NAME Florence Reynolds

(a) RESIDENCE NO. 1605 E Chase St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Geo. H. Reynolds

DATE OF BIRTH (month, day, and year) May 30-1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	19	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H W - 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Benj. M. Tracy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary F. King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant H. E. Reynolds (Son)
(Address) 1722 Nelson Ave

Filed ..... 19 ..... Registrar

C. HAMPSON REGISTRAR
JUN 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19-1930.

17 I HEREBY CERTIFY, That I attended deceased from 4-28-, 1930, to 5-19-, 1930,
that I last saw h. alive on 5-19-, 1930,
and that death occurred, on the date stated above, at 12.45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.
Chronic Myocarditis.
(duration) yrs. 2 mos. 22 ds.
CONTRIBUTORY (Secondary) Cardiac dilatation
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None
Did an operation precede death? Date of
Was there an autopsy? none
What test confirmed diagnosis? Urinalysis.

(Signed) George Abner Bowden, M. D.
5/19/, 1930 (Address) 1517 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount
DATE OF BURIAL May 22 1930

20 UNDERTAKER Leach Bros.
ADDRESS 1600 N. North Ave.

Spec.—1-30—M. & T.—250 Bks.

E 57339 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57339

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1505 N. Lamvale ST. 16-22 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Delaney Matthews

(a) RESIDENCE NO. 1505 N. Lamvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Widow

6 If married, widowed, or divorced HUSBAND of or) WIFE of George Matthews

DATE OF BIRTH (month, day, and year) Dec 15-1874

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	4	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer Matthew Co

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Eliza Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Anna Jackson

(Address) 1505 N. Lamvale St

FILED JUN 9 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 19TH 30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1930, to May 19, 1930,

that I last saw her alive on 18, May, 1930,

and that death occurred, on the date stated above, at 5.30 a m.

The CAUSE OF DEATH* was as follows:

Cebreal Hemorrhage

(duration) XX yrs. 5 mos XX ds.

CONTRIBUTORY (Secondary) Nephritis (Institial)

(duration) XX yrs. 5 mos. XX ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of XXX

Was there an autopsy? XXXX

What test confirmed diagnosis? XXX

(Signed) A. White, M. D.

5-20 1930 (Address) 1021 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn

DATE OF BURIAL May 21, 1930

20 UNDERTAKER Samuel N. Chase Inc

ADDRESS 1400 Mosher

Spec.--1-10-21—M&T—1500 Blks. (Charles R. Lamm)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57340 E 57340

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Joseph's Hospital WARD 5)

2-FULL NAME Charles Lamm

(a) RESIDENCE NO. 821 Eastern Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louisa Lamm

6 DATE OF BIRTH (month, day, and year): April 1 1873

7 AGE: Years 57 Months 1 Days 17

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Port Deposit Md.

PARENTS

10 NAME OF FATHER: Henery Lamm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Port Deposit Md

12 MAIDEN NAME OF MOTHER: Sara Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible] Md.

14 Informant: Louisa Lamm

(Address) 829 Eastern Ave

DATE RECEIVED 1930 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-18 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-15, 1930, to 5-18, 1930, that I last saw h[illegible] alive on 5-18, 1930, and that death occurred, on the date stated above, at 2 [illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic Syphilis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) S. Robert Sands, M. D.

, 19 (Address) St Joseph's Hospital 3405 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: May 22 1930

20 UNDERTAKER: M. W. & Deppel Inc — ADDRESS 37 Lanvale

Spec.—1-10-21—M&T—1500 Bks.

E 57341

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57341

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST. 16-22 WARD)

2-FULL NAME Jack Kane.

(a) RESIDENCE NO. 914 N. Fulton Ave ST. City WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Anna L Keane

6 DATE OF BIRTH (month, day, and year) Feb 23 1877

7 AGE: Years 53 Months 2 Days 27 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Newspaper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas Keane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Leonora Applegarth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Jack Kane. 914 N. Fulton Ave

15 Filed ... 19 ... Registrar

Rec'd 1930 C. HAMPSON JONES, M. D. City

Rec'd NRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20 1930

17 I HEREBY CERTIFY, That I attended deceased from 5/18, 1930, to 5-20, 1930, that I last saw ~~him~~ alive on 5-20, 1930, and that death occurred, on the date stated above, at 5 10 a. m.

The CAUSE OF DEATH* was as follows: Daylight Saving

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) ... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Ernest Spencer p. ..., M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jamaica N.Y.

DATE OF BURIAL 5/21/30

20 UNDERTAKER Empire Undertaking Co

ADDRESS Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

(Weigman)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57342

CERTIFICATE OF DEATH

129

E 57342

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 603 Mt Hoey ST. 16-11 WARD)

2—FULL NAME Michael A. Weigman

(a) RESIDENCE NO. 603 Mt Holly ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Ely. Weyman

DATE OF BIRTH (month, day, and year) July 16 18[illegible]

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	10	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Joseph Weyman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Ely Weyman

(Address) 603 Mt Holly St

Filed ..... 19 ..... Registrar C. HAMPSON JONES, M. D.

0 1930 Bur

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/19/30

17

I HEREBY CERTIFY, That I attended deceased from Jan 2 1930, to May 19, 1930, that I last saw him alive on May 19, 1930 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Cardiac Hypertrophy with Arteriosclerosis. Chronic Nephritis

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

Pulmonary Oedema (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy Examination & Hearing

(Signed) W. Duncan, M. D.

5/19 1930 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 5/21/30

20 UNDERTAKER George A. Tuley Sulton

ADDRESS Fayette

Spec.—1-30—M. & T.—250 Bks.

E 57343

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57343

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH Mercy Hospital. 4-25 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST.

2-FULL NAME Charles Evans

(a) RESIDENCE NO. 125 Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

a If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 25 1899

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	6	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER William Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lena Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Hospital Record
(Address)

MAY 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-16-30

17 I HEREBY CERTIFY, That I attended deceased from 5-11, 1930, to 5-16, 1930, that I last saw him alive on 5-16, 1930, and that death occurred, on the date stated above, at 6 43 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 da.

CONTRIBUTORY (Secondary) Pneumococcic Meningitis

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

5/16, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

UNIVERSITY OF MARYLAND

UNDERTAKER Commissioner Health. ADDRESS MAY 20 1930

Per Wm. E. SEGRALL

Spec.—1-30—M. & T.—250 Bks.

E 57344 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57344

CERTIFICATE OF DEATH. 128

REGISTERED NO. 27-41

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital ST., WARD

CITY OF BALTIMORE: (NO.

2-FULL NAME Herman Roberts

(a) RESIDENCE NO. 3112 Harford Rd ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 31st 1900

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	4	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Sandford-Brooks

(c) Name of employer "

BIRTHPLACE (city or town) (State or country) Wales

10 NAME OF FATHER Morgan Robert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

Informant Hospital Records

(Address)

C. HAMPSON JONES, M. D.

Filed MAY 21 1930 Registrar

0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1930

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to May 20, 1930, that I last saw h[illegible] alive on May 20, 1930, and that death occurred, on the date stated above, at 9 5A m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

5/20, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnstown Pa.

DATE OF BURIAL 5/21/1930

20 UNDERTAKER Wm Cook

ADDRESS 1207 St Paul st

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 57345

E 57345

CERTIFICATE OF DEATH

REGISTERED NO. 27-57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4838 Park Heights Ave ST. 27-57 WARD 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George W. Glenn

(a) RESIDENCE NO. 4838 Park Heights Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie B. Glenn

DATE OF BIRTH (month, day, and year) May 16 1858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	72	0	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Henry Glenn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliza Morningstar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

Informant Mrs. Glenn

(Address) 4838 Park Heights Ave

Filed ..., 19 ... Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) may 18-1930

17 I HEREBY CERTIFY, That I attended deceased from May 2 1930, to May 18th 1930, that I last saw him alive on May 18th 1930 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Heart Block,

Chronic Mitral Endocarditis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) 3 yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) C.S. Evans, M. D.

5-20 1930 (Address) 4936 Park Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL 5/21 1930

20 UNDERTAKER D. J. Fenwick McCully

ADDRESS 1306 E. Fort

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57346

CERTIFICATE OF DEATH.

49 E 57346

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 E. Potomac St. WARD) 1-2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry John Luckhardt.

(a) RESIDENCE NO. 626 E Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Luckhardt

6 DATE OF BIRTH (month, day, and year): Sept. 14, 1847

7 AGE: Years 82; Months 8; Days 15; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): General housekeeping

(c) Name of employer: City of Balto

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry L. Luckhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. John Luckhardt (Son)

(Address) 620 E. Potomac St.

15 [illegible] 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 18, 1930, that I last saw him alive on May 18, 1930, and that death occurred, on the date stated above, at 6.20 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder (Primary)

(duration) yrs. 1 mos. ds.

None other

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exp.

(Signed) O. L. Long, M. D.

5-19-1930 (Address) 2711 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cemetery

DATE OF BURIAL: May 22 1930

20 UNDERTAKER: Henry Sander & Sons Inc

ADDRESS: Baltimore St & Broadway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57342

E 57347

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE (No. Caroline & Orleans St., (WARD) 8-13

2-FULL NAME Elizabeth Dorsey

(a) RESIDENCE NO. 1727 E Biddle St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 3rd 1915

7 AGE Years 14 Months 9 Days 16

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 069

(b) General nature of industry, business, or establishment in which employed (or employer) Quilt Box

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore. Md

(State or country)

PARENTS

10 NAME OF FATHER Geo. R. Dorsey

11 BIRTHPLACE OF FATHER (city or town) Baltimore. Md

(State or country)

12 MAIDEN NAME OF MOTHER Florence Reedent

13 BIRTHPLACE OF MOTHER (city or town) Baltimore. Md

(State or country)

14 Informant Maurice Dorsey

(Address) 1727 E. Biddle St

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/19/1930

17 I HEREBY CERTIFY, That I attended deceased from 5-12-30. 19 to 5-19-30. 19

that I last saw her alive on 5-19-30. 19

and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Streptococcic Appendicitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Peritonitis & Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5-13-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Lindsay, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel.

DATE OF BURIAL 5/22/30

20 UNDERTAKER J. B. Neppert 1850 N. Balto St

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 57348 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57348

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (NO. 14-20 ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Smith

(a) RESIDENCE NO. 520 Wilson St. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

a If married, widowed, or divorced HUSBAND of or) WIFE of Alexander

DATE OF BIRTH (month, day, and year) Feb. 19-1868

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	4		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Bertha Watson

(Address) 520 Wilson St

C. HAMPSON JONES, M. D.

Filed 5-20-1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/20/30

17 I HEREBY CERTIFY, That I attended deceased from 4/19/30, 19..., to 5/20/30, 19...,

that I last saw h alive on 5/20/30, 19...,

and that death occurred, on the date stated above, at 1 30 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus c

cellulites of L. Lower extremity

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 4/20/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Jones, M. D.

5/20/30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 5/23/1930

20 UNDERTAKER Mrs Lea H. Holland

ADDRESS 1631 Druid Hill

Spec.—8-16-29—L. F. S.—100 Bks.

37066 E 57349

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 57349

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wyatt Madden

(a) RESIDENCE NO. 1228 Druid Hill ST., Case — WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

6 If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Frances

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Unknown

10 NAME OF FATHER James Madden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER Laura Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

Informant Friends —

(Address) JOHNS HOPKINS HOSPITAL

Filed ....., 19..... C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19-30

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to May 19, 1930, that I last saw him alive on May 19, 1930 and that death occurred, on the date stated above, at 5 45 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis, following

drainage of Pelvic Abscess.

(duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 5-16-30

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Edward Simonton M. D.

5/20 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
H. Lukes - Reisterstown Md	5/22/30

20 UNDERTAKER Chas. Sp. Holland ADDRESS 1631 Druid Hill Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57350

CERTIFICATE OF DEATH.

91-E 57350

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2025 Eutaw St. 23 WARD)

2-FULL NAME Salvatore Bianca

(a) RESIDENCE NO. 2025 Eutaw ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~Wife of~~ Jennie Bianca

6 DATE OF BIRTH (month, day, and year) November 2 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60.	4.	14.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) for Self

(c) Name of employer Nothing

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Maria Stella Giordano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Saveria Bianca

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joseph Bianca

(Address) 2025 Eutaw St.

Filed 1930 C. HAMPSON JONES, M. D. 19 Registrar

By MKB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-18 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-18-, 1930, to 5-18, 1930, that I last saw h[illegible] alive on 5-18, 1930 and that death occurred, on the date stated above, at 2:30 P. m

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

Endarteritis obliterans.

(duration) ? yrs. mos. da.

CONTRIBUTORY (Secondary) Gangrene foot -

Toxic. (duration) yrs. 2 mos. - da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Bruno M. D.

5-20 1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL May 22 1930.

ADDRESS

20 UNDERTAKER Kendall & Riepel

ADDRESS 300 S Edwards

Spec.—1-30—M. & T.—250 Blks

E 57351 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57351

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1834 N. Bond ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Capt. Benjamin Pratt

(a) RESIDENCE NO. 1834 N. Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Lee

DATE OF BIRTH (month, day, and year) 1/12/1850

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	4	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain. O.S.

(b) General nature of industry, business, or establishment in which employed (or employer) Ocean Going

(c) Name of employer Steamers. Phila. Pa.

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Benj. Pratt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Sarah Purdue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila.

Informant Laura Lee

(Address) 1834 N. Bond St

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/19/30

17 I HEREBY CERTIFY, That I attended deceased from 4/10, 1930, to 5/19, 1930, that I last saw h— alive on 5/19, 1930, and that death occurred, on the date stated above, at 11.15 a m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis – (infectious)
Chronic Myocarditis
(duration) yrs. 1 mos 9 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dean Barden, M. D.

May 20, 1930 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 5/21/30

20 UNDERTAKER Mary V. Pugh Sr.

ADDRESS 1035 Hanford Av

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57352

CERTIFICATE OF DEATH

90 E 57352

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 57352

1-PLACE OF DEATH

City of Baltimore: (No. 302 East St. St., 5-8 Ward)

2-FULL NAME Barbara Bryan

(a) RESIDENCE NO. 302 East St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Bryan

6 DATE OF BIRTH (month, day, and year) 9-1-1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	75	8	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Own home
(c) Name of employer

9 BIRTHPLACE (city or town) Penna.
(State or country)

PARENTS

10 NAME OF FATHER E. Maitland

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Warner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Anna Canales
(Address) 302 East

Registered 1930 G. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 192 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv dis Lung

Cardiac (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. T. Kelly Coroner, M. D.

May 21, 1930 (Address) 1639 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pottstown, Pa.

DATE OF BURIAL 5/21/30 19

20 UNDERTAKER Mary T. Pugh

ADDRESS 1735 Harford Ave

Dwg

Spec.—8-16-29—L. F. S.—100 Bks.

236923
B57353

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001
E 57353

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 45-75 ST. WARD) JOHNS HOPKINS HOSPITAL

2—FULL NAME Ruth Miles

(a) RESIDENCE NO. 205 3rd Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Brooklyn Md yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

6 If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Claude

DATE OF BIRTH (month, day, and year) 1-10-92

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	4	10	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Edgar Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Derenberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Family
(Address) JOHNS HOPKINS HOSPITAL

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20-30

17 I HEREBY CERTIFY, That I attended deceased from 5-12, 1930, to 5-20, 1930, that I last saw her alive on 5-20, 1930 and that death occurred, on the date stated above, at 10⁵ P. m.

The CAUSE OF DEATH* was as follows:
Lupus Erythmus Toxa - 3 yrs.
Ac tonsilit - ? (Cure)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia - Lobar Pneumonia (duration) 3-5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hedwig Kreuz, M. D.
19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 5/22 1930.

UNDERTAKER Drew McCully

ADDRESS 128 E Mort

21 1030 JOHNS HOPKINS HOSPITAL

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57354

CERTIFICATE OF DEATH

99-001

E 57354

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charlotte Wade

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1862

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER Ralph Wade

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER Charlotte Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

Informant Little Sisters of the Poor

(Address) Preston & Valley

Filed MAY 21 1930 19 [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 1930

17 I HEREBY CERTIFY, That I attended deceased from 5/5, 1930, to 5/19, 1930, that I last saw h[illegible] alive on 5/18, 1930 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Lees M. D.

May 20, 1930 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: May 21 1930

20 UNDERTAKER: Rita Wiedefeld — ADDRESS: 914 Fremont Ave

Spec.—1-30—M. & T.—250 Blks.

E 57355 HEALTH DEPARTMENT—CITY OF BALTIMORE 109-002 E 57355

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Apartments ST. 17-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary McEvers Taylor Tucker

(a) RESIDENCE No. Homewood Apartments ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Robert Tucker

DATE OF BIRTH (month, day, and year) Dec. 6-1853

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, Md (State or country)

10 NAME OF FATHER William W. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Augusta Birckhead

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

Informant Robert Tucker (Address) Homewood Apartments

Filed MAY 1 1930 H. Hanson Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 - 1930

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1930, to May 20, 1930, that I last saw h[illegible] alive on May 20, 1930, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows: Staphylococcus Haemolyticus Blood Stream infection

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Staphylococcus Infection

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Cultures

(Signed) Chas W Lamont M. D.

May 20 1930 (Address) 132 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem DATE OF BURIAL May 22 1930

20 UNDERTAKER Henry A Jenkins Sons Co ADDRESS McCulloh & Orchard Sts.

Spec.—1-30—M. & T.—250 Blks

E 57356 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57356

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1740 E 20th St ST. 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Serafina Scavone

(a) RESIDENCE NO. 1740 E 20th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? ~0 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Giacomino Scavone

DATE OF BIRTH (month, day, and year) 1/29/1887

AGE Years	Months	Days	If LESS than 1 day hrs. or min.
43	3	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Michael Grasino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER A S Santa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

Informant Giacomino Scavone

(Address) 1740 E 20th St

Filed 5-31-1930 H. HAMPSON JONES, M. D. Registrar

Dat Early

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1930

17

I HEREBY CERTIFY, That I attended deceased from March 29, 1930, to May 20, 1930,

that I last saw her alive on May 20, 1930,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

Chronic Interstitial Nephritis

(duration) 3 yrs. mos da.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Laboratory findings

(Signed) Wilmer Fort, M. D.

5/21, 1930 (Address) 20 East Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 5/23/1930

20 UNDERTAKER Mary T. Ruth

ADDRESS 1135 Hanover

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57357

CERTIFICATE OF DEATH

74081

E 57357

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2317 Fremont Ave ST. ..... WARD 26-23

2—FULL NAME Fannie Washington

(a) RESIDENCE NO. 2317 Fremont Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (Write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of .....

DATE OF BIRTH (month, day, and year) 1863

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Petersburg Va

10 NAME OF FATHER Nelson McRae

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER Nancy ?

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va

Informant Ira Russell

(Address) 2317 Fremont Ave

Filed ..... 1930 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 13 1930, to May 19, 1930, that I last saw h alive on May 19 1930 and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Coeta (Hemorrhage)

4

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. Chesley, M. D.

, 19 (Address) 1627 Lamb

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem DATE OF BURIAL May 22 1930

20 UNDERTAKER Samuel Stanley ADDRESS 578 Biddle

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57358

CERTIFICATE OF DEATH

129 E 57358

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 869 Boyd St St. 18-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Scott

(a) RESIDENCE NO. 869 Boyd St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Scott

6 DATE OF BIRTH (month, day, and year) mar 15, 1888

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	42	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) md

PARENTS

10 NAME OF FATHER William Scott

11 BIRTHPLACE OF FATHER (City or town)

(State or country) md

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) md.

14 Informant James E Scott

(Address) 869 Boyd St

15 Filed 19 Registrar

C. HAMPSON MILES, M.D.

1930 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/19 1930

May 19, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 19, 1930,

that I last saw h alive on May 19, 1930,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY Chronic Nephritis obesity.

(Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no. (Urine Analysis)

What test confirmed diagnosis? Physical Exam etc.

(Signed) J. Thaddeus Johnson, M. D.

19 (Address) 888 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Zion Cemetery

Date of Burial May 22, 1930

20 UNDERTAKER

Mrs. Katie R. Williams

ADDRESS 322 Schroeder St

Spec.—1-30—M. & T.—250 Blks.

E 57359 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57359.

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore City Hospitals (TB) REGISTERED NO.

CITY OF BALTIMORE: (No. 15-12 ST. (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bates

(a) RESIDENCE NO. 1004 Mason Alley ST., WARD
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) 4/19/1900

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29		28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Odd)

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown.

BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Elridge Bates

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Eleanor Butler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

Informant Hospital Records (Address)

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17/30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1930, to 5/17/30, 19....,

that I last saw him alive on 5/17/30, 19....,

and that death occurred, on the date stated above, at 6 10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Undefinite period

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Jas. Arnold Jr., M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL May 21, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 3224 Schroeder St.

1930 C. HANSON JONES, M.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57360 ✓ 37 E 57360

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 18-46 WARD)

CITY OF BALTIMORE: (NO. ..... ST. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Laws

(a) RESIDENCE NO. 949 940 Bennett Place ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

f1 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1910

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
20			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

Informant Hospital Records
(Address)

Filed 6-6-30 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to May 19, 1930, that I last saw her alive on May 19, 1930, and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & lab.

(Signed) Jas. Glennon Jr. M. D.

5-19-30 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery

20 UNDERTAKER Mrs. Katie R. Williams

DATE OF BURIAL May 20, 1930

ADDRESS 322 N Schroeder St

Spec.—2-29-28—L. F. S.—500 Bks.

E 57361 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57361

CERTIFICATE OF DEATH

REGISTERED NO. 24-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Argyle ST. 17-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Bloxom

(a) RESIDENCE NO. 906 Argyle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Bloxom

DATE OF BIRTH (month, day, and year) Feb 8, 1880

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	3	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER James Bloxom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Emma ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Annie Bloxom

(Address) 552 Wilson St.

Filed MAY 24 1930, 19 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to May 19, 1930.

that I last saw h[illegible] alive on May 19, 1930

and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL May 22, 1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N. Schroeder St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

B 36 7/12 57362

31 E 57362

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Geneva Byrd

(a) RESIDENCE NO. 657 W. Lee St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 11 - 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Everett Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Lillie Byrd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ala

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 5-21 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 20 - 1930

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to May 20, 1930, that I last saw her alive on May 20, 1930 and that death occurred, on the date stated above, at 3 40 A m.

The CAUSE OF DEATH* was as follows:

Multiple abscesses (staphylococcus) in lungs and other organs

(duration) yrs. mos. 19 ds. (about)

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Tuberculin test for Tuberculosis

(Signed) Leary Adams, M. D.

5-20, 1930 (Address) Johns Hopkins Hosp, Bal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	May 21 1930
20 UNDERTAKER	ADDRESS
Joseph A Lively	1029 Monument E

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57363

CERTIFICATE OF DEATH

90 E 57363

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. City Hospital St. 21-31 Ward)

2-FULL NAME Jacob Baylor.

(a) RESIDENCE NO. 1103 Brocot St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec 27. 1872.

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
57	4	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labour
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Jacob Baylor
11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland
12 MAIDEN NAME OF MOTHER Mary Smith
13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Rebecca Allstine
(Address) 1103 Brocot St

15 Filed MAY 21 1930 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Work Compensation

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? — What test confirmed diagnosis? History

(Signed) A. C. Earle, M. D.

19 (Address) 14-36 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL May 21 1930

20 UNDERTAKER Joseph A Lively ADDRESS 409 N mount St

Spec.—2-29-28—L. F. S.—500 Bks.

E 57364

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57364

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 313 E. Cross ST. 24-33 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry M. Busick

(a) RESIDENCE NO. 313 E. Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 1 mos. 22 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Mar. 27, 1905

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	1	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Car Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: B. & O. R. R.

BIRTHPLACE (city or town) (State or country): Baltimore, Md.

10 NAME OF FATHER: George Busick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Cora Jervis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

Informant: Mrs. Ella F. Cripps

(Address): 313 E. Cross St.

Filed 1-1930, 19 RPK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 13th, 1930, to May 19th, 1930, that I last saw him alive on May 19th, 19, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, gastric

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptomatic.

(Signed) Robert W Johnson, M. D.

, 19 (Address) 3564 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: May 22 1930

20 UNDERTAKER: John F Denny

ADDRESS: 15 S 15th St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57365

CERTIFICATE OF DEATH

179 ✓ E 57365

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 1-1 Ward)

2-FULL NAME Norbert Ptaszynski

(a) RESIDENCE NO. 1200 S Ellwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6 1927

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
2	11	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Alexander Ptaszynski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes Malinoske

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Alexander Ptaszynski
(Address) 1200 S Ellwood Ave

15 Filed MAY 21 1930 C. HAMPSON JONES M. D. Registrar

By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fall in bucket Lot water

Acc. Burns 3rd Degree

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

18 Where was disease contracted (If not at place of death?) —

What duration precede death? Date of —

Was There an autopsy? No

What were confirmed diagnosis? History

(Signed) C. C. Yates M. D.

. 19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cemetery	May 21 st 1930
20 UNDERTAKER Lilly & Zirkin Inc.	ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Bks.

E 57366 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57366

71-002

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2744 St. Paul ST. 17-50 WARD)

2-FULL NAME William Edgar Helldorfer

(a) RESIDENCE No. 2744 St. Paul ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 19 1902

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	8		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Frank Helldorfer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Anna Reiter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

Informant Frank Helldorfer (Father)
(Address) 2744 St. Paul St.

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-19-30

17 I HEREBY CERTIFY, That I attended deceased from May-15-, 1930, to May-19-, 1930, that I last saw h[illegible] alive on May-19-, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:
Cerebro-Spinal Meningitis —

(duration) ....yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Coma —
(duration) ....yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) [signature], M. D.

, 19 (Address) 125 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

UNDERTAKER Lilly + Zeiler Inc.

DATE OF BURIAL May 22 1930

ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Blks.

E 57367 ✓ E 57367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-001

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital ST. 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No.

2-FULL NAME Robert Stephens

(a) RESIDENCE NO. 24 N. Pearl ST., WARD Usual

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER James Stephens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER McKenny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Hosp. Records

(Address)

1 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20-30

17 I HEREBY CERTIFY, That I attended deceased from 5-18, 1930, to 5-20, 1930, that I last saw him alive on 5-20, 1930, and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyhe M. D.

5/20, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hookstown NC — DATE OF BURIAL 5/21/30

20 UNDERTAKER Geo. A. Fuller & Son — ADDRESS Fayette

Spec.—1-10-21—M&T—1500 Bks.

E 57368 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57368

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3017 Westwood Ave St., 15-67 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Rebecca Dunbar

(a) RESIDENCE NO. 3017 Westwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. 10 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of Henry F. Dunbar

6 DATE OF BIRTH (month, day, and year) June 21-1839

7 AGE: Years 90 Months 10 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Andrew Stoll

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S. A. Md

12 MAIDEN NAME OF MOTHER ? Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Blanche F. Turbert

(Address) 3017 Westwood Ave

15 Filed 2 1930 19 PLH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 8 1930 to May 20 1930

that I last saw h[illegible] alive on May 20 1930

and that death occurred, on the date stated above, at 3.55 P m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emil K Palm M. D.

5/20, 1930 (Address) 3000 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem.

DATE OF BURIAL: May 22, 1930

20 UNDERTAKER: J. J. Tickner & Sons

ADDRESS: North Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57369

178

E 57369

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. B. & P. R. Co. Coal Pier Curtis Bay St., 25-7 Ward)

2-FULL NAME Skull found May 13, 1930 Body found May 14, 1930 Unknown (C)

(a) RESIDENCE NO. Do not know. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
About 30	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S. D.
(Address)

Filed MAY 21 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Missing Jan. 4, 1927 Found May 13 & 14 1930.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burned and buried in pitch. Due to an explosion aboard the s/s Richelieu January 4, 1927. Occidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Otto H. Fenstad, M. D.

5/20, 1930 (Address) 107 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL MAY 21 1930

20 UNDERTAKER Commissioner Health

ADDRESS

THE MORGUE

Per. Wm. E. Woods

Spec.—8-16-29—L. F. S.—100 Bks.

2B 1091 57370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 57370

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 22-30 WARD)

2—FULL NAME Limes Givens

(a) RESIDENCE NO. 542 W. Barre St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

6 If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Alberta

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) S. Car.
(State or country)

10 NAME OF FATHER Herbert Givens

11 BIRTHPLACE OF FATHER (city or town) S. C.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) S. Car.
(State or country)

Informant Records
(Address)

Filed ..... 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19-30

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to May 19, 1930, that I last saw him alive on May 19, 1930 and that death occurred, on the date stated above, at 7:50 a.m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Myocardial Insufficiency

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) ? Pulmonary Infarct

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Hedwig Koenig, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary Cemetery

DATE OF BURIAL 5/20 1930

20 UNDERTAKER Walter B. Boniface

ADDRESS 1391 Ulleman St

JOHNS HOPKINS HOSPITAL C. HAMILTON SAUNDERS, M.

2 T 1930

Spec.—8-16-29—L. F. S.—100 Bks.

Gridew ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

23706 E 57371 — CERTIFICATE OF DEATH — 129 E 57371

Med.

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Teiden

(a) RESIDENCE NO. 223 Register ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Michael

DATE OF BIRTH (month, day, and year) 1890

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) — 0?

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Slade Andrew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant JOHNS HOPKINS HOSPITAL

(Address)

JUN 21 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20-30

17 I HEREBY CERTIFY, That I attended deceased from 5-16, 1930, to 5-20, 1930, that I last saw her alive on 5-20, 1930 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis - 8 mo

Hypertension

Cardiac Hypertrophy

Uremia (duration) ....yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Accidental (duration) ....yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Hed wig Assay

(Signed) Johns Hopkins, M. D.

5/20, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery DATE OF BURIAL May 24 1930

20 UNDERTAKER George A. Weber ADDRESS 705 S. Amm st.

Spec.—2-29-28—J. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57372

CERTIFICATE OF DEATH

E 57372

REGISTERED NO. 8

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 27-56 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Chas. Edgar Chapman

(a) RESIDENCE NO. 4926 Palmer Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Jan. 26, 1923

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	3	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Walter D. Chapman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ida E. Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Walter D. Chapman

(Address) 4926 Palmer Ave

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to May 20, 1930, that I last saw him alive on May 20, 1930 and that death occurred, on the date stated above, at 10 20 a. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Fuller, M. D.

5/20, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	5/22 1930
UNDERTAKER Henry U. Mears and Son	ADDRESS 805 N. Calvert

Spec.—1-30—M. & T.—250 Blks

E 57373 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-9 E 57373

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 237 Myrtle Ave ST., 4-16

2-FULL NAME Catherine Johnson

(a) RESIDENCE NO. 237 Myrtle Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of W. H. Johnson

DATE OF BIRTH (month, day, and year) 1892

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
38		—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

Informant Wm H Johnson

(Address) 237 Myrtle ave

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1930, to May 20, 1930, that I last saw him alive on May 20, 1930, and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 9 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. Cassady, M. D.

, 19 (Address) 1701 Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 5-21 1930

20 UNDERTAKER David Carter — ADDRESS 916 Eager

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57374 E 57374

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1716 W La Fayette Ave WARD 17

2-FULL NAME John Hughes

(a) RESIDENCE NO. 1716 W La Fayette Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE: Years 19 | Months — | Days —

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New Jersey

10 NAME OF FATHER Royal Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mamie Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant (Address) Royal Hughes 1716 W La Fayette Ave

Filed MAY 21 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1930

17 I HEREBY CERTIFY, That I attended deceased from May 7 1930, to May 18 1930, that I last saw him alive on May 17th 1930, and that death occurred, on the date stated above, at 7:30 p m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonic Phthisis

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ..... Date of —

Was autopsy?

What test confirmed diagnosis?

(Signed) H. J. Howell M. D.

(Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 5-21 1930

20 UNDERTAKER Frank Taylor

ADDRESS 926 Penna

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57375

CERTIFICATE OF DEATH

E 57375

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hosp St., 4-6 Ward)

2-FULL NAME Martin Hogan

(a) RESIDENCE NO. 614 S. Pratt St., Ward

(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
64	Unk		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 067
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 ~~BIRTHPLACE OF MOTHER~~ (city or town)
(State or country)

14 Informant Coroner
(Address)

15 Filed 1 1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted —
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) A. J. Ruhy Corner, M. D.
May 21 1930 (Address) 1 S. Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York 5/24 DATE OF BURIAL 1930

20 UNDERTAKER Geo. A. Fahy ADDRESS Fulton, Fayette

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57376

101-001

E 57376

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No.) Providence Hosp S. 14-70 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David H. Beckett

(a) RESIDENCE NO. 1620 Division Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Alice

6 DATE OF BIRTH (month, day, and year): Aug 6 1897

7 AGE: Years 32 | Months 9 | Days 4 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Va
(State or country)

PARENTS

10 NAME OF FATHER: Geo. Beckett

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Collins

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country)

14 Informant: Alice Beckett
(Address): 507 N. Mount

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

E 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) F. H. Bush, M. D.

May 20 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — DATE OF BURIAL: 5/23/1930

20 UNDERTAKER: Jos. Geo. H. Holland — ADDRESS: 1631 Druid Hill

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57377

90 E 57377

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 514 N Stricker St. 7-11 Ward)

2-FULL NAME Minnie L. Eaton

(a) RESIDENCE NO. 514 N. Stricker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Howard E Eaton

6 DATE OF BIRTH (month, day, and year) Feb. 7-1880

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country)

PARENTS

10 NAME OF FATHER Herman Anacker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte Bilenbecker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Howard E. Eaton

(Address) 514 N Stricker St

HAMPSON JONES, M. D.

Registrar

MAY 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20-1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Odema

(duration) yrs. mos. ds.

(Signed) J. H. Kolb M. D.

(Coroner)

5/21/30 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial May 23, 1930

20 UNDERTAKER A. S. Marshall ADDRESS 3539 Fait Ave.

Spec.—1-30—M. & T.—250 Blks.

E 57378 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57378

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp (ST.) 27-41 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genevieve Bassetti

(a) RESIDENCE NO. ~~Sinai Hosp~~ 4244 Nicholas Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	white	M.

6 If married, widowed, or divorced (or) WIFE of Married

DATE OF BIRTH (month, day, and year) ~~Sept~~ 24-1900

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	—	8	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housefe

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Bradford Penn.

10 NAME OF FATHER Henry Clayson

11 BIRTHPLACE OF FATHER (city or town) Bradford (State or country) Penna.

12 MAIDEN NAME OF MOTHER Minnie Swartwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

Informant Mr. Bassetti

(Address) 106 Forrestville Ave

Filed 1-1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to May 21, 1930, that I last saw her alive on May 21, 1930, and that death occurred, on the date stated above, at 12.05 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Rheum. carditis
Mitral Stenosis & Insuff.
Aortic Insufficiency

(duration) yrs. 17 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. H. Conn, M. D.

19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL May 24 1930

20 UNDERTAKER E. W. Conklin — ADDRESS 924 Eager St

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 57379 — CERTIFICATE OF DEATH. — 90 E 57379

REGISTERED NO. 28-66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4312 Sidehill Rd ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helene Therese Kabisius

(a) RESIDENCE NO. 4312 Sidehill Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) July 11th 1885

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER C B. Kabisius

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Martha C. Cukerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Erich B. Stein

(Address) 4312 Side Hill Road

Filed 5 22 1930 C. HAMPSON JONES, M. D. Registrar

Per R.H.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/19/30

17 I HEREBY CERTIFY, That I attended deceased from 1928 to 5/19 1930

that I last saw h alive on 5/19 1930,

and that death occurred, on the date stated above, at 11.25 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatic Cardiovascular disease.

Mitral Stenosis.

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Auricular Fibrillation

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) W. Thom, M. D.

, 19 (Address) Mud Lick Bedford.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: May 22 1930

UNDERTAKER: Harry M Jenkins Sons Co

ADDRESS: Richard Ga-Co Md

Spec.—1-12-23—M&T—500 Blks.

E 57380 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57380

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH 1614 White Ave REGISTERED NO.

CITY OF BALTIMORE: (No. 1614 ST. White Ave WARD 16-42)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Shirley Engle

(a) RESIDENCE NO. 1614 White Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto, Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm. W. Engle

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mildred North

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mildred North
(Address) 1614 White Ave

15 Filed MAY 2 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to May 21, 1930,

that I last saw her alive on May 20, 1930,

and that death occurred, on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency, compensation

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) L. Sobilof, M. D.

5/21, 1930 (Address) 407 N. Howard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Clevet

DATE OF BURIAL 5/24 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-10-21—M&T—1500 Bks.

E 57381

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57381

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1263 Washington Blvd. 7-1-29 (WARD)

2-FULL NAME Lena Vogel

(a) RESIDENCE NO. 1263 Washington Blvd. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem. | 4 COLOR OR RACE: W | 5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick

6 DATE OF BIRTH (month, day, and year) Feb 23. 1864

7 AGE: Years 66 | Months 5 | Days 28 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Bertha Burnes (Address) 1263 Washington Blvd

15 Filed 5 21 1930 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930. to May 21, 1930.

that I last saw her alive on May 21, 1930.

and that death occurred, on the date stated above, at 10:30 A. m. Standard.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Stamm M. D.

5/21, 1930 (Address) 1901 Griffis Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer | DATE OF BURIAL 5/24 1930

UNDERTAKER Kehoe & Cook. | ADDRESS 1217 E. Fayette St

Spec.—1-30—M. & T.—250 Bks

Dr Wordy 1403 Park Ave

E 57382 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 57382

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1770 E. North Ave ST. 8-17 WARD)

2-FULL NAME Anna L. Franzke

(a) RESIDENCE NO. 1770 E. North Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Herman L. Franzke

DATE OF BIRTH (month, day, and year) 1891

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Wm A. Fryer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Herman L. Franzke
(Address) 1770 E. North Ave

Filed ..... 19 ..... Registrar

2 2 1930 HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, to May 20, 1930.

that I last saw her alive on May 20, 1930,

and that death occurred, on the date stated above, at May 21-30 3 A. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. A. Wordy, M. D.

, 19 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 5/23 1930

20 UNDERTAKER Wm. Cook

ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-001 E 57383

E 57383

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 E Biddle ST. 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Brown

(a) RESIDENCE NO. 1628 E Biddle ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 6 mos. 3 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) November 17th 1865

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	6	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: John W. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norway

12 MAIDEN NAME OF MOTHER: Wilhelmina Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Betty Brown

(Address): 1628 E Biddle St

Filed MAY 22 1930 H. [illegible] MAFS, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1929, to May 20, 1930,

that I last saw h.. alive on May 20, 1930

and that death occurred, on the date stated above, at 8.40 P. m. Standard Time

The CAUSE OF DEATH* was as follows:

1 Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) 3½ yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm B Leonard M. D.

5/31, 1930 (Address) 718 N Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: May 23rd 1930

UNDERTAKER: George S Dilling & Sons

ADDRESS: 1226 Druid Park Dr

Spec.—2-29-28—L. F. S.—500 Bks.

E 57384 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57384

CERTIFICATE OF DEATH

REGISTERED NO. 44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1734 S. Hanover ST. 7-3-32 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence B Whittington

(a) RESIDENCE NO. 1734 Hanover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Joseph J Whittington

DATE OF BIRTH (month, day, and year) Oct 15th 1867

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	7	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER James Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Kingsley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Joseph J Whittington

(Address) 1734 S Hanover St

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to May 20, 1930, that I last saw HER alive on May 20, 1930 and that death occurred, on the date stated above, at 9:47 a. m. Standard time

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) R. B. H. Campbell, M. D.

5/20, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL May 24 1930

20 UNDERTAKER George Schilling & Sons

ADDRESS 420 E Monument St

Spec.—8-16-29—L. F. S.—100 Bks.

E 57385 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 E 57385

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irwin Slade

(a) RESIDENCE NO. 917 Hillman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Aug-2-1929

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Md (State or country)

10 NAME OF FATHER Calvin Slade

11 BIRTHPLACE OF FATHER (city or town) N.C (State or country)

12 MAIDEN NAME OF MOTHER Martha Farrell

13 BIRTHPLACE OF MOTHER (city or town) N.C (State or country)

Informant Records

(Address) [illegible]

Filed [illegible] 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 - 1930

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 19, 1930, that I last saw h[illegible] alive on May 19, 1930 and that death occurred, on the date stated above, at 1135 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia (primary)

7 days

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. 7

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) J V Bickford, M. D.

5/21, 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery

DATE OF BURIAL May 23 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Edmondson ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57386

CERTIFICATE OF DEATH

129

E 57386

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 416 N. Pulaski ST. 70-69 WARD)

2—FULL NAME Ella T. Ford

(a) RESIDENCE NO. 416 N. Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced, HUSBAND of (or) WIFE of: John Henry Ford

DATE OF BIRTH (month, day, and year): Feb 18-1869

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	3	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Crisfield Md

10 NAME OF FATHER: Thos. Stirling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Crisfield Md.

12 MAIDEN NAME OF MOTHER: Sarah Walden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

Informant: John H. Ford

(Address): 416 N. Pulaski St

Filed 6-2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21-1930

17

I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to May 21, 1930

that I last saw h live on May 20, 1930

and that death occurred, on the date stated above, at 7.25 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

5/21. 1930 (Address) 1663 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: May 23 1930

20 UNDERTAKER: Geo. A. Tuttle

ADDRESS: 700 Edmondson Av

Cor.—10-19-29—A Co.—100 Bks.

E 57387

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

165 E 57387

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Provident Hosp. St., 14-70 Ward

2-FULL NAME Goldie Taylor

(a) RESIDENCE NO. 1944 Edmondson Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): Oct 22-1909

7 AGE: Years 20 | Months 7 | Days 2 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: No.

9 BIRTHPLACE (city or town): No. (State or country)

PARENTS

10 NAME OF FATHER: Theo Taylor

11 BIRTHPLACE OF FATHER (city or town): W. Va. (State or country)

12 MAIDEN NAME OF MOTHER: Nattie Taylor

13 BIRTHPLACE OF MOTHER (city or town): W. Va. (State or country)

14 Informant: Nattie Taylor (Address): 1944 Edmondson Ave

15 Filed: MAY 7 1930 Registrar: C. HAMILTON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide Drank Shoe Blacking

(duration) yrs. 5 hours

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) C. H. Jones M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: May 5 1930

20 UNDERTAKER: Virginia A Brooks

ADDRESS: 1463 N Carey

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57388

E 57388

CERTIFICATE OF DEATH

REGISTERED NO. 178

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1510 N. Spring St St., 9-17 Ward)

2-FULL NAME John L Carter

(a) RESIDENCE NO. 1510 N. Spring St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Carter

6 DATE OF BIRTH (month, day, and year) Sept 14/1883

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	46	8	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer) 014
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Trbin Carter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Sarah McLaughlin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Margaret Carter
(Address) 1510 N. Spring St.

15 Filed ..., 19.. C. HAMPSON GORE, M. D. Registrar

For 2 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21-1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol Shot Wound- Rt Temple

Suicide

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. O. Wolf, M. D.

5/22/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 24 1930
20 UNDERTAKER	ADDRESS
Henry Hoeck Sons Inc	130 E Eager

Spec.—1-12-23—M&T—500 Bks.

E 57389 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 90 E 57389

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Levindale

CITY OF BALTIMORE: (No. Hebrew Immigrants Home ST. 27-54 WARD

2-FULL NAME Mrs. Jennie Stein

(a) RESIDENCE NO. Belvedere Ave. Cold Spring Lane ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: White | 4 COLOR OR RACE: Female | 5 Single, Married, Widowed, or Divorced. (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Stein

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
89				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Russia

Informant J. Lewis
(Address) 1439 Eutaw St

Filed 5 22 1930 19 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to May 21, 1930,
that I last saw her alive on May 21, 1930
and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular heart disease

(duration) 10 yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wilmund Levin, M. D.

, 19 (Address) Levindale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Northern Ave. | DATE OF BURIAL 5-22-1930

20 UNDERTAKER Jack Lewis, 1439 Eutaw St | ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 57390 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57390

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp. ST. 15-6 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Lesser

(a) RESIDENCE NO. 4023 Norfolk Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	wht	m

If married, widowed, or divorced HUSBAND of or) WIFE of Hyman Lesser

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Joseph Lesser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant (Address) I. Levin 1439 E Balto St

Filed ..... 19 ..... Registrar

2-1930 HARRY JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1930

17

I HEREBY CERTIFY, That I attended deceased from Feb 16, 1930, to May 22, 1930, that I last saw h[illegible] alive on May 22, 1930, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

hypertensive C.V. disease

C

congestive cardiac failure

arterio sclerosis (duration) 14 yrs. (?) mos. ds.

CONTRIBUTORY (Secondary) diabetes mellitus

(duration) [illegible] yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) [illegible] Cohn, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shaw Walsh Road DATE OF BURIAL 5-22 1930

20 UNDERTAKER Jacob Levin ADDRESS 1439 E Balto

Spec.—2-29-28—L. F. S.—500 Blks.

E 57391 HEALTH DEPARTMENT—CITY OF BALTIMORE 159-002 E 57391

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 N Bethel ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard E. Collins

(a) RESIDENCE NO. 421 N Bethel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) June 19, 1929

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		10	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto md

10 NAME OF FATHER James H. Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Alberta Bruce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Worcester Mass.

Informant Alberta Collins

(Address) 421 N. Bethel St.

Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to May 19, 1930,

that I last saw him alive on May 19, 1930

and that death occurred, on the date stated above at 9:15 P.m.

The CAUSE OF DEATH* was as follows: Broncho

Unresolved Pneumonia

(duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. J. Sperry, M. D.

5/21, 1930 (Address) 429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary cem

DATE OF BURIAL May 23, 1930

20 UNDERTAKER Mrs. R. G. Ellicott

ADDRESS 123 E Baltimore

Spec.—1-30—M. & T.—250 Bks.

57392

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 E 57392

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 8-12 ..... WARD)

2-FULL NAME Helen Benner

(a) RESIDENCE NO. 1118 No. Milton av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single.

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 11/26/25

AGE	Years	Months	Days 24	If LESS than 1 day, ... hrs. or ..... min.
	5	3	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) Balto Md.
(State or country)

10 NAME OF FATHER Geo Benner.

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Schmaltz

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

Informant Hospital Records.
(Address) .....

Filed ..... 1930 C. HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/20/30

17 I HEREBY CERTIFY, That I attended deceased from 5/20, 1930, to 5/20, 1930, that I last saw her alive on 5/20, 1930, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

appendicitis

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 5/20/30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Wm N. McFaul Jr. M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	May 3 1930
20 UNDERTAKER Vernon Kechner	ADDRESS 1537 Hollins

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57393

CERTIFICATE OF DEATH

74-00 E 57393

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 20-24 Ward)

2-FULL NAME Alberto De Luca

(a) RESIDENCE NO. 2574 W. Fairmount Av. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 17 mos. da. How long in U. S., if of foreign birth? yrs. 17 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna De Luca

6 DATE OF BIRTH (month, day, and year) Aug. 2 - 1868

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	61	9	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Francesco DeLuca

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Domenica Muffoletta

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Anna De Luca
(Address) 2574 W. Fairmount Av

15 Filed ..., 19... C. HAMBLETON [illegible] M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fillers M. D.

5/19. 1930. (Address) 139 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL May 23 1930

20 UNDERTAKER Frank V. Pipitone — ADDRESS 2818 E. Balto St

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57394

CERTIFICATE OF DEATH

129

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 249 S. Madeira St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Henry Gross

(a) RESIDENCE NO. 249 S. Madeira St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband of Doris Gross

6 DATE OF BIRTH (month, day, and year) June 17 — 1887

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	42	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Roofer. 115

(b) General nature of industry, business, or establishment in which employed (or employer) Roofing Business.

(c) Name of employer Lewis Tyler Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Gross

11 BIRTHPLACE OF FATHER (City or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margt. Eder.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Catherine A. Gross (Address) 306 S. Madeira St.

15 Filed MAY 22 1930 C. HAMPTON LEWIS M. Registrar

Per RWH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 — 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to May 19, 1930, that I last saw She alive on May 19, 1930, and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 2 mos. 30 da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Geo Vogel, M. D.

(Address) 5-21-30 19 1005 Mount St.

*State the Disease Causing Death, or in deaths from Violence, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

Date of Burial May 23rd 1930

20 UNDERTAKER Lilly & Zeiler One

ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Blks.

E 57395

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57395

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 Carnegie Ave ST. 26-37 WARD)

2-FULL NAME John J Kalb

(a) RESIDENCE NO. 1303 Carnegie Ave ST., 26 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mary B Kalb

DATE OF BIRTH (month, day, and year) Aug 10 1861

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	9	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or estsblishment in which employed (or employer) Of the B&O RR

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Kalb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mary B Kalb His Wife

(Address) 1303 Carneige Ave

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1930

17 I HEREBY CERTIFY, That I attended deceased from 2 P.M. May 19th, 1930, to May 19th, 1930, 5:30 P.M.

that I last saw him alive on May 19th 1930,

and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cardiac Dilatation (duration) yrs. mos. 8 hrs ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) C. Klasing, M. D.

, 19 (Address) 0833 Fropper Rd Dundalk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacreds Hearts Cemetary

DATE OF BURIAL: May 23 1930

20 UNDERTAKER: Lilly & Zeiler Inc

ADDRESS: 403 S Wolfe

Cnr.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

E 57396 — REGISTERED NO. E 57396

1-PLACE OF DEATH Mercy Hospital

City of Baltimore: (No. Lan 25 19[illegible] St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm F. Martin

(a) RESIDENCE NO. Irving Home St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	~~M~~ Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Gov
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm A. Martin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Margaret Costello

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Mrs Walter Curran
(Address) 130 Valley

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. F. Martin, M. D.

May 21 1930 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park

DATE OF BURIAL May 23 1930

UNDERTAKER Rita Riedefeld

ADDRESS 14 Greene St

Cor.—10-10-29—A Co.—100 Bks.

E 57397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 101-801

E 57397

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 4-30 Ward)

2-FULL NAME Frances E. Crawford

(a) RESIDENCE NO. Odenton, Md St., _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. 1 ds. How long in U. S., If of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE ~~of~~ Howard Crawford

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) Md

PARENTS

10 NAME OF FATHER John Tydings

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Md

12 MAIDEN NAME OF MOTHER Betty Griffith

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Md

14 Informant Fielder Crawford
(Address) Odenton, Md.

15 Filed _____, 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Empyema

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) Wayne Fellers, M. D.

May 22 1930 (Address) 273 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Odenton Md — DATE OF BURIAL May 24 1930

20 UNDERTAKER Lloyd Kaiser — ADDRESS Laurel Md.

Spec.—2-29-28—L. F. S.—500 Bks.

Sumans 90

E 57398

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57398

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 108 E. North Ave ST., 12-19 WARD)

2—FULL NAME M. Elizabeth Sumans —

(a) RESIDENCE NO. 108 E. North Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	white	widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Saml. Sumans

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
c	94	-		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Gft. Graves.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER E. A. Sims

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Rev Eckman

(Address) 108 E. North Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21-1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to May 21, 1930, that I last saw h alive on May 21 - , 1930, and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Renal: Just worn out entire heart not affected.. organs all in proper order

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. [illegible] M. D.

. 19 (Address) 108 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 5/23 1930

20 UNDERTAKER J. P. Russell & Sons

ADDRESS 2620 Pa Ave

Filed 2-1930 C. HAMPSON JONES, M. D. Registrar

By CCB

Spec.—1-10-21—M&T—1500 Bks.

E 57399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 57399

REGISTERED NO. 1612

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) St Agnes Hosp. (Ward) 16-70
2-FULL NAME Baby boy Fusselbaugh.
(a) RESIDENCE No. 626 Linnard St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-20-30

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
36 hours	0	0		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo P. Fusselbaugh
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md
12 MAIDEN NAME OF MOTHER Edith Hendricks
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Geo P. Fusselbaugh.
(Address) 626 Linnard St. City

15 1930 . 19 16th Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-21 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-20 . 1930 . to 5-21 . 1930 .
that I last saw him alive on 5-21 . 1930 P.M. . m.
and that death occurred, on the date stated above, at [redacted]
The CAUSE OF DEATH* was as follows:

Prematurity
(7 mo. fetus)
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) George Brenner M. D.
. 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral
DATE OF BURIAL 5/23 1930
20 UNDERTAKER L. P. Fusselbaugh 26 E Pratt
ADDRESS

Spec.—1-30—M. & T.—250 Blks

E 57400

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57400

CERTIFICATE OF DEATH.

100

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Etting St. 20 WARD)

2-FULL NAME Anna Hafer

(a) RESIDENCE NO. 1721 Etting ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of James Goiner

7 DATE OF BIRTH (month, day, and year) ? ? 1892

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	98			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Washerwoman

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Balto. ? Md.

10 NAME OF FATHER ? Hicks

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

Informant James Goiner
(Address) 1721 Etting St.

C. HAMPSON JONES, M. D.
Registrar

FILED 19 MAY 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 - 30

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1930, to May 22 1930, that I last saw h.. alive on May 21, 1930, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma.
Broncho - Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) H. & Arteriosclerosis of Heart
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) E. J. Marr, M. D.

5.22. 1930 (Address) 516 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 5-22 1930

20 UNDERTAKER David Eaton

ADDRESS 716 Pa ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57401 | 61-09 | E 57401

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2535 Fait ave ST., 1 (6) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Manzola

(a) RESIDENCE NO. 2535 Fait ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 5-20-30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	—	20 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER Lorenzo Manzola.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Carlina Perno.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

Informant

(Address)

Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20-1930

17

I HEREBY CERTIFY, That I attended deceased from 12:25 A.M. May 20 19 30 to 1:45 A.M. May 20 19 30

that I last saw h alive on May 20 1930 at 1:45 A.M. 19

and that death occurred, on the date stated above, at 1:45 A.M.

The CAUSE OF DEATH* was as follows: Premature birth (6½ months) Baby lived about 20 minutes after birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Evolution of Perforation + Cardiac action.

(Signed) W. A. Anderson, M. D.

19 (Address) 2419 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE OF BURIAL MAY 21 1930

20 UNDERTAKER Commissioner Health.

ADDRESS

E. WOOD

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57402

CERTIFICATE OF DEATH

E 57402

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank A. J. Wood

(a) RESIDENCE NO. 118 Mulberry St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1872

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work mechanic 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) New York

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Hospital Record

(Address)

Filed ..., 19 ... C. HAMPSON JONES, Registrar

By ...

MAY 23 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-21-30

17

I HEREBY CERTIFY, That I attended deceased from May 17, 1930 to May 21, 1930

that I last saw him alive on May 21, 1930

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis

secondary anaemia

arterial hypotension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Possible cerebral thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) W. H. Varney, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Matthews Cem	May 23 1930
20 UNDERTAKER	ADDRESS
Jos. L. Herr	156 N. Luzerne

Spec.—8-16-29—L. F. S.—100 Blks.

E 57403 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 57403

CERTIFICATE OF DEATH

REGISTERED NO.....

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 116 E. Gittings ST. 24-33 WARD)

2—FULL NAME Gertrude Bolander

(a) RESIDENCE NO. 116 E. Gittings ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Wh.	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Bolander

DATE OF BIRTH (month, day, and year) Feb. 5, 1887

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	3	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Chas H. Baer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Katherine Otte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

Informant John W. Bolander

(Address) 116 E. Gittings St

Filed 3 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24/30

17 I HEREBY CERTIFY, That I attended deceased from 5/19/30 to 5/24/30

that I last saw her alive on 5/22/30

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 23 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) 16 Dulaney Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL 5/24 1930

20 UNDERTAKER F. A. Ward & Son — ADDRESS 783 Hamm

Spec.—1-30—M. & T.—250 Blks.

E 57404

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57404

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3008 E. Monument St. 11-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara M. Schrieber

(a) RESIDENCE NO. 3008 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred: yrs. 24 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Henry Schrieber

DATE OF BIRTH (month, day, and year): Dec 21/02

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	4	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer: 037

BIRTHPLACE (city or town) (State or country): City

10 NAME OF FATHER: James Pinkus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Louise Lupinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

Informant: Henry Schrieber

(Address): 3008 E. Monument

Filed: 3-1930. 12

C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 30

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to May 26, 1930,

that I last saw h[illegible] alive on May 26, 1930,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Acute Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. Ned Doughty M.D.

(Address) 600 N. Dallas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill

DATE OF BURIAL: 5/23 1930

UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57405

CERTIFICATE OF DEATH

20 E 57405

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore (a) No. Standard Oil Co Haur & O'Donnell St., 26-37 Ward

2-FULL NAME John R Bierman

(a) RESIDENCE NO. 3414 Fait Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa A. Bierman

6 DATE OF BIRTH (month, day, and year) July 29. 1895

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	34	9	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boiler Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Standard Oil Co.

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles Bierman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Augustine Bierman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Louisa A Bierman
(Address) 3414 Fait ave

231930 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Bruises & Fracture

Instant (duration) yrs. mos. da.

CONTRIBUTORY Shock (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

What test confirmed diagnosis?

(Signed) C. C. Yates, M. D.

19 (Address) 143 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartzbach Cemetery

DATE OF BURIAL May 26 1930

20 UNDERTAKER George W Zickler

ADDRESS 1737 E. Eager St

Spec.—8-16-29—L. F. S.—100 Blks.

E 57406 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57406

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH REGISTERED NO. 16-22

CITY OF BALTIMORE: (No. 1830 Mosher ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Goldie M Walker

(a) RESIDENCE NO. 1830 Mosher ST., WARD
(Usual place of abode) (If non-resident give rity or town and State)

Length of residence in city or town where death ocrurred 40 yrs. 4 mos 21 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

If married, widowed, or divorced HUSBAND of (or) WIFE of Leon W Walker

DATE OF BIRTH (month, day, and year) ~~Aug~~ Dec 30 90

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39	40	4	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home 037

(r) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Charles Harding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary L Smith

13 BIRTHPLACE OF MOTHER (rity or town) (State or country) Md.

Informant Leon W Walker

(Address) 1830 Mosher St

Filed C. HAMPSON JONES, M. D. Registrar

MAY 23 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 30

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 21, 1930, that I last saw h[illegible] alive on May 20, 1930 and that death occurred, on the date stated above, at 11 55 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contrarted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? P.E. - Elect. Cardio. Xray

(Signed) Wm L. Dodd, M. D.

5/22 1930 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 22 5 m 1930

20 UNDERTAKER W Maurice Routson

ADDRESS 2238 N Mott

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57407 179 E 57407

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 57407

1-PLACE OF DEATH

City of Baltimore: (No.) 2524 Druid Hill Ave St., 13-54 Ward

2-FULL NAME Mary E. Young

(a) RESIDENCE NO. 2524 Druid Hill Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 18 68

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	65	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Estelle Pettigrew
(Address) 2524 Druid Hill Ave

Filed APR 23 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Morrison, M. D.

4/22 1930 (Address) 7832 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lawn

DATE OF BURIAL 4/23 1930

20 UNDERTAKER Samuel K. Lemley

ADDRESS 570 Biddle

Cor.—10-10-29—A Co.—100 Bks.

Bibb

HEALTH DEPARTMENT—CITY OF BALTIMORE

57 ✓ E 57408

CERTIFICATE OF DEATH

E 57408

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hospt. St., Ward)

2-FULL NAME Leroy Bill

(a) RESIDENCE NO. 430 Merryman's Lane Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	C.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9, 1922

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	8	0	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Morton Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Atlanta Bill

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Atlanta Bill.
(Address) 430 Merrymans Lane

Filed 5 23 1930 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes-at Hopkins

What test confirmed diagnosis?

(Signed) L. Colen, M. D.

5/23/30 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Cohen cemetery — DATE OF BURIAL May 23 1930

20 UNDERTAKER Mrs. R. G. Ellicott — ADDRESS 1725 Ashland Ave

Spec.—1-30—M. & T.—250 Blks.

E 57409 HEALTH DEPARTMENT—CITY OF BALTIMORE 40 E 57409

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 1014 WARD)

2-FULL NAME Henry Smith

(a) RESIDENCE NO. 781 Eutaw ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of .....

7 DATE OF BIRTH (month, day, and year) Dec 18 1884

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Newport News
(State or country) Virginia

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) North Carolina

Informant Hospital Record
(Address) UNIVERSITY OF MARYLAND

Filed ..... C. HARRISON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-19-30

17 I HEREBY CERTIFY, That I attended deceased from 5-12, 1930, to 5-19, 1930, that I last saw him alive on 5-19, 1930, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Urethral Structure - urinary extravasation - Gangrene of penis and scrotum

(duration) Unknown mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of 5-14-30

Was there an autopsy? No Incision + Drainage

What test confirmed diagnosis? Clinical

(Signed) P. H. Pumphrey, M. D.

5-20 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL .....

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS MAY 23 1930

Spec.—1-30—M. & T.—250 Bks.

E 57410 HEALTH DEPARTMENT—CITY OF BALTIMORE E/57410

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.....ST.) 12-50 (WARD)

2-FULL NAME Nannette Gaither

(a) RESIDENCE NO. 322 W. 28th ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Mack Gaither

DATE OF BIRTH (month, day, and year) Dec. 25, 1894

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	4	16.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Chester

(State or country) S. C.

10 NAME OF FATHER Wm. Allen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) S. C.

12 MAIDEN NAME OF MOTHER Nancy Dye

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S. C.

Informant Records of

(Address) Balto. City Hosp.

FILED 6-3 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-21-30

17 I HEREBY CERTIFY, That I attended deceased from 4-8-30, 19..., to 5-21-30, 19...,

that I last saw her alive on 5-21-30, 19...,

and that death occurred, on the date stated above, at 4 A. ....m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum, left

(duration) ....yrs. ....mos 12 ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis, Rt. 2 mos

Myocarditis, chronic (duration) 4 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. McLean, M. D.

5-21, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Great Falls S.C.

UNDERTAKER Chas. G. Cooper

DATE OF BURIAL 5-23 1930

ADDRESS 3142 Caelum St

Spec.—8-16-29—L. F. S.—100 Bks.

E 57411

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 ✓ E 57411

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Hunterstz Hosp ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara V. Bauer

(a) RESIDENCE NO. 510 S Montford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 4 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Bauer

DATE OF BIRTH (month, day, and year) Jan. 6, 1872

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58.	4	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto (State or country) Md.

10 NAME OF FATHER Joseph Helm

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Jennie Diamond

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

Informant Mr. Henry H. Bauer

(Address) Windsor Mill Rd

Filed MAY 23 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22/30.

17 I HEREBY CERTIFY, That I attended deceased from 5-19, 1930, to 5-22, 1930, that I last saw h[illegible] alive on 5-22, 1930 and that death occurred, on the date stated above, at 1 00 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & laboratory

(Signed) Henry F. Merrick, M. D.

5/23, 1930 (Address) Hunterstz Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Memorial Cem.

DATE OF BURIAL May 26, 30

20 UNDERTAKER Wm J. McKnew Sons

ADDRESS North & Pa

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57412

CERTIFICATE OF DEATH.

74-001 to Villa

E 57412

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 940 S. Conkling ST., 27-39 WARD

2-FULL NAME Paul Baier

(a) RESIDENCE NO. 940 S. Conkling ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of or) WIFE of the late Amelia Baier

DATE OF BIRTH (month, day, and year) June 2nd 1866

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	4	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto. Md.
(State or country)

10 NAME OF FATHER John Baier

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

Informant Edward A. Baier
(Address) 17?? Bank St.

FILED JUN 23 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21st 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to May 21, 1930,

that I last saw h[illegible] alive on May 21, 1930,

and that death occurred, on the date stated above, at 12 40 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Gradual yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B. Tatlow, M. D.

6/23 1930 (Address) 815 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL May 26th 1930

20 UNDERTAKER Lilly & Julia Inc

ADDRESS 403 S. Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57413 ✓ 34 E 57413

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Conrad Stewart

(a) RESIDENCE NO. 1914 E. Chase ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jamie L. Stewart

6 DATE OF BIRTH (month, day, and year) Feb. 27 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or empioyer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER Henry M. Stewart

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine K. Berger

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Jamie L. Stewart (Address) 1914 E. Chase St.

15 Filed 23 1930 Reg. 2447 Registrar C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1930

17 I HEREBY CERTIFY, That I attended deceased from April 3 1930, to May 22 1930, that I last saw him alive on May 22 1930, and that death occurred, on the date stated above, at 12:15 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of spine

P

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of 4-28-30

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) M. Cumbury M. D.

(Address) Keeps Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL May 26 30

20 UNDERTAKER Frederick Leahmus ADDRESS Gilbertson

Spec.—1-30—M. & T.—250 Bks.

E 57414

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 1001 E 57414

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3900 Pinewood St., (Ward) 43

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Russell Davis Jr.

(a) RESIDENCE NO. 3900 Pinewood Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Aug 11th 1928

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9	11	

9 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Howard Russell Davis

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret E. Edwards

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Maryland

Informant Howard Russell Davis

(Address) 3900 Pinewood Ave.

Filed 1930, C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to May 22, 1930,

that I last saw him alive on May 22, 1930,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Cretinism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Wheeler, M. D.

(Address) 4309 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL May 24th 30

20 UNDERTAKER Fred Loose — ADDRESS Forest Hill

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57415

CERTIFICATE OF DEATH.

1617 E 57415

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 W Fayette St. 19-27 WARD)

2-FULL NAME Baby Boy Lucido

(a) RESIDENCE NO. 1602 W Fayette St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 22 1930

7 AGE: Years ..... Months ..... Days ..... If LESS than 1 day 24 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Lucido

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Virginia Shepherd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Virginia Lucido 1602 W Fayette St

15 Filed 3-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1930

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1930, to May 22, 1930, that I last saw h/m alive on May 22, 1930, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. Morris Shaw M. D.

May 22 1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL MAY 23 1930

20 UNDERTAKER Baltimore City Health Dept.

ADDRESS

Spec.—1-30—M. & T.—250 Blks.

E 57416 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57416

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE, No. Good Shepherd Hosp St. 15-21 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy F Hall

(a) RESIDENCE No. 1606 N. Calhoun St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 5 mos. 10 da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	Col.	Single

6 If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 12-1902

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	5	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Marion Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S. A.

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

Informant Marion Hall

(Address) 1606 N. Calhoun St

Date 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22-30

17

I HEREBY CERTIFY, That I attended deceased from 5-6-30, 19..., to 5-22-30, 19...,

that I last saw him alive on 5-22-30, 19...,

and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

General Toxaemia due to infection from broken arm (open)

(duration) yrs. mos 20 da.

CONTRIBUTORY (Secondary) Broken arm, from a fall

(duration) yrs. mos. 20 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W R Boykin, M. D.

5-23 1930 (Address) 1512 Belmont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 25 1930
20 UNDERTAKER	ADDRESS
Sam'l N. Chase & Son	1400 Mosher

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57417

CERTIFICATE OF DEATH.

E 57417

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hilton Court Apartments (STREET OR AVENUE) (WARD) 15-61

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Collins Durham

(a) RESIDENCE. NO. Liberty Heights Ave. & Hilton St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Durham

6 DATE OF BIRTH (month, day, and year) ------

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Dennis Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine O'Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Miss M. Louise Durham S.W.Cor.Liberty Hgts.Ave.& Hilton St.

15 Filed 3 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1930. to May 22. 1930.

that I last saw her alive on May 22. 1930.

and that death occurred, on the date stated above, at 10.42 p. m. [Standard Time]

The CAUSE OF DEATH* was as follows:

Cerebral Endarteritis
(Cerebral Haemorrhage)

(duration) 0 yrs. 0 mos. 1 ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) 10 yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dohme, M. D.

5/23/ 1930 Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 5/26 1930

20 UNDERTAKER: Henry U. Mears and Son

ADDRESS: 805 N. Calvert

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57418

CERTIFICATE OF DEATH

180-003 E 57418

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at

City of Baltimore: (No. St. Joseph Hospital St., 7-11 Ward)

2-FULL NAME Thomas E Tracey

(a) RESIDENCE NO. 818 N. Linwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Birdie E. Tracy

6 DATE OF BIRTH (month, day, and year) Nov 1/1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57	6	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Park Board-Balto. City

9 BIRTHPLACE (city or town) Cockeysville, Md.
(State or country)

PARENTS

10 NAME OF FATHER John T. Tracy

11 BIRTHPLACE OF FATHER (city or town) Butler, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Virginia Perryman

13 BIRTHPLACE OF MOTHER (city or town) Reistertown, Md.
(State or country)

14 Informant Mrs. Birdie Tracy
(Address) 818 N. Linwood, Md.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar.

3 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22/30 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came this death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suffocation-Cave in of ditch in which he was laying sewer pipe; in Clifton Park. Accidental

(ducation) yrs. mos. da.

CONTRIBUTORY (Secondacy)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Cairns, M. D.

5/23/1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bissops Amtrin Cemetery

DATE OF BURIAL May 26 1930

20 UNDERTAKER George Schillington Sons

ADDRESS 1426 E Monument St

Spec.—1-30—M. & T.—250 Blks

St. James North & Penna Ave

E 57419

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57419

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2623 Woodbrook Ave St.) 13-59 (WARD)

2-FULL NAME Henry Faulstich

(a) RESIDENCE NO. 2623 Woodbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Standard Corset

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced — HUSBAND of ~~or WIFE~~ Gertrude Faulstick

7 DATE OF BIRTH (month, day, and year) 10/14/1880

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	7	9	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O+O

(b) General nature of industry, business, or establishment in which employed (or employer) City Park Dept

(c) Name of employer Park Board

10 BIRTHPLACE (city or town) (State or country) Balto Md

11 NAME OF FATHER John K Faulstick

12 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

13 MAIDEN NAME OF MOTHER Barbara Zigler

14 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

15 Informant Gertrude Faulstick (Address) 2623 Woodbrook Ave

16 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/23/30

17 I HEREBY CERTIFY, That I attended deceased from about one year to May 23, 1930, that I last saw him alive on May 23, 1930, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual symptoms

(Signed) Fred C. Jewett, M. D.

19 (Address) 2576 Penn-ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 5/26/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 E Paul St

E. HAMPSON HOWARD M.D.

Spec.—1-30—M. & T.—250 Bks.

E 57420 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57420

CERTIFICATE OF DEATH.

REGISTERED NO. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3907 Canterbury Rd ST. 12-44 WARD)

2-FULL NAME Rogr Allen Harmon

(a) RESIDENCE NO. 3907 Canterbury Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) May 12, 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			11	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Samuel Harmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Staunton Va

12 MAIDEN NAME OF MOTHER Elsie Hazelwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Emma Harmon

(Address) 3907 Canterbury Rd

Filed MAY 31 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23. 1930

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 23, 1930,

that I last saw him alive on May 22, 1930,

and that death occurred, on the date stated above, at 3 A- m.

The CAUSE OF DEATH* was as follows:

Embolus

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M Bauman Hurd, M. D.

5/22 1930 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Crematorium

DATE OF BURIAL 5/26/1930

20 UNDERTAKER H. M. Cook

ADDRESS 1217 E Fond St

Spec.—1-30—M. & T.—250 Bks.

E 57421 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57421

CERTIFICATE OF DEATH. X 31

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. W-7 Ward)

2-FULL NAME Elizabeth Taylor

(a) RESIDENCE NO. Brookville Rd St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2/ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Samuel Taylor

6 DATE OF BIRTH (month, day, and year) Sept 30, 1894

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

10 NAME OF FATHER Wm L Clark

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Payne

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hospital Records
(Address)

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22/30

17 I HEREBY CERTIFY, That I attended deceased from 5/4/30, 19..., to 5/22/30, 19..., that I last saw h.. alive on 5/22/30, 19..., and that death occurred, on the date stated above, at 7 45 P.m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) pregnancy (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical x-ray

(Signed) Frank K. Morris, M. D.

, 19 (Address) 1129 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Potomac Park Md — DATE OF BURIAL 5/24 1930

20 UNDERTAKER J. M. Cook — ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57422

CERTIFICATE OF DEATH.

161-2011 V

E 57422

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No.) ST. (WARD) 7

2-FULL NAME Baby Taylor

(a) RESIDENCE NO. Beachville Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

6 If married, widowed, or divorced HUSBAND of or) WIFE of Single

7 DATE OF BIRTH (month, day, and year) 5-22-30

8 AGE	Years	Months	Days	If LESS than 1 day 3 hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) Balto (State or country) Md.

10 NAME OF FATHER Samuel Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Estelle Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

PARENTS

14 Informant Hospital Records.

(Address)

Filed 5 23 1930 C. HAMPSON JONES, M. D. Registrar.

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22-30

17 I HEREBY CERTIFY, That I attended deceased from 5-22, 1930, to 5-22, 1930, that I last saw h[er] alive on 5-22, 1930, and that death occurred, on the date stated above, at 2 45 P. m.

The CAUSE OF DEATH* was as follows:

Premature

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyho, M. D.

5/22, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Potomac View. Md

DATE OF BURIAL 5/24 1930

20 UNDERTAKER J. W. Cook

ADDRESS 1217 E Gaul St

Spec.—1-30—M. & T.—250 Bks.

E 57423 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57423

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2658 Frederick Ave ST. 20-64 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida P. Thomas

(a) RESIDENCE NO. 2658 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Louis Thomas

6b DATE OF BIRTH (month, day, and year): Nov 9th 1859

7 AGE: Years 70 | Months 6 | Days 13 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 31

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore Md

(State or country)

10 NAME OF FATHER Wm Dittman

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary Scoopy

13 BIRTHPLACE OF MOTHER (City or town) Baltimore Md

(State or country)

14 Informant Ida P Thomas

(Address) 2658 Frederick Ave

Filed 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24/30

17 I HEREBY CERTIFY, That I attended deceased from May 15 1930 to May 24 1930

that I last saw her alive on May 24 1930

and that death occurred, on the date stated above, at 2 15 A. m.

The CAUSE OF DEATH* was as follows:

Perforated Duodenal Ulcer

1 (duration) yrs. mos da.

CONTRIBUTORY (Secondary) Chr Bronch Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? Surgical Findings

(Signed) W. A. Kreel, M. D.

May 25, 1930 (Address) Towson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: May 27th 30

20 UNDERTAKER: F. A. Weyant — ADDRESS: 1850 N. Broadway

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57424 91 E 57424

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2010 Edgewood St. (Ward) 15-67

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Grey

(a) RESIDENCE No. 2010 Edgewood St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40+ yrs. mos. ds. How long in U. S., If of foreign birth? 40+ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Grey

6 DATE OF BIRTH (month, day, and year) 1847 Sept 3

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	89	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Broadway Worchestershire England

PARENTS

10 NAME OF FATHER Charles Race

11 BIRTHPLACE OF FATHER (city or town) (State or country) Worchestershire England

12 MAIDEN NAME OF MOTHER Sarah Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) London England

14 Informant Lawrence Test

(Address) 2010 Edgewood St.

15 Filed 3 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1930

17

I HEREBY CERTIFY, That I attended deceased from 18 hrs., 19..., to May 22, 1930,

that I last saw her alive on May 22, 1930,

and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows: Hemorrhage Lung

Arteriosclerosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia Hypostatic

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic Symptoms

(Signed) William J. Todd, M. D.

, 19 (Address) 2217 Druid Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery Elkridge Md

DATE OF BURIAL May 24 1930

20 UNDERTAKER Chas. G. Black

ADDRESS 742 W. Fort Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 57425

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57425

CERTIFICATE OF DEATH

129

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1702 Pressbury ST. 15-21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Jones

(a) RESIDENCE NO. 1702 Pressbury ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Jones

DATE OF BIRTH (month, day, and year) Dec 24 1870

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	5	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Church

(c) Name of employer Seventh Day Adventist

BIRTHPLACE (city or town) (State or country) Frederick Md

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

Informant Agnes Jones

(Address) 1712 Pennsylvania Ave

C. HAMPSON JONES, M. D.

May 25, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1930, to May 23, 1930, that I last saw h.. alive on May 22, 1930 and that death occurred, on the date stated above, at 10.20 A m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Age - Arteriosclerosis

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm. H. Wright, M. D.

May 23, 1930 (Address) 1709 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL May 26th 1930

UNDERTAKER Lawrence E. Whitbeck

ADDRESS Carrollton Ave

1930

Spec.—1-30—M. & T.—250 Bks.

E 57426

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57426

105

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. S. W. Cor Gay + Exeter ST. 5-8 WARD)

2-FULL NAME Charles E. Hamill

(a) RESIDENCE NO. S. W. Cor Gay + Exeter ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Hamill

6 DATE OF BIRTH (month, day, and year) June 5th 1858

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Alexander Hamill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Elizabeth Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Agnes Hamill

(Address) 1322 W. Exeter St.

15 Filed 4 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24th/30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16th, 1930, to May 23rd, 1930, that I last saw h[illegible] alive on ..., 19..., and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Emphysema

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Bronchial asthma

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L. Winner, M. D.

5-24, 1930 (Address) 302 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL May 26 1930

20 UNDERTAKER Lilly + Zeiler Inc

ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Bks.

E 57427 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 57427

E 57427

CERTIFICATE OF DEATH. + 111-002

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caulinor Oliver ST.) 9-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Richardson

(a) RESIDENCE NO. Girdletree Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 17 da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Laura A Richardson

6 DATE OF BIRTH (month, day, and year) May 21 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura Richardson

(Address) Girdletree Md

15 Filed 24 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to May 23, 1930,

that I last saw him alive on May 23, 1930,

and that death occurred, on the date stated above, at 6 35 A.m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home 5/9/30

Did an operation precede death? Yes No Date of 5/22/30

Was there an autopsy?

What test confirmed diagnosis?

(Signed) V. Mergins, M. D.

, 19 (Address) St Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (i) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Girdletree Md

DATE OF BURIAL May 24 1930

20 UNDERTAKER George L Smith

ADDRESS 153 W Hollins St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57428

E 57428

CERTIFICATE OF DEATH.

58-601

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2336 Mc.Culloh St. 13-54 WARD)

2-FULL NAME Alice V. Holt

(a) RESIDENCE NO. 2336 Mc.Culloh ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)				
7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min
	19	10	12	

August 11, 1910

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Northampton Co. Va.

10 NAME OF FATHER James H. Holt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Northampton Co. Va.

12 MAIDEN NAME OF MOTHER Nellie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Northampton Co. Va.

14 Informant Nellie Williams(sister)
(Address) 104 N. Mount St.

15 Filed 4 1930, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1930

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to May 23, 1930

that I last saw her alive on May 23, 1930

and that death occurred, on the date stated above, at 1;50 p.m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. 1 mos 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Northampton Co. Va.

DATE OF BURIAL May 24, 1930

20 UNDERTAKER Mrs. Katie R Williams

ADDRESS 322 N Schroeder St

Spec.—1-30—M. & T.—250 Bks.

E 57429 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57429

90

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 N Ellwood Ave ST. 1-V WARD)

2-FULL NAME Jackson P. Algenstitz

(a) RESIDENCE NO. 108 N Ellwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Virlie Algenstitz

DATE OF BIRTH (month, day, and year) Jan 27 1864

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	3	25 26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Joiner

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Jackson P. Algenstitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Louisa Lowrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mrs Virlie Algenstitz
(Address) 108 N Ellwood Ave

Filed ..... 19 ..... Registrar

C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22-1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 8, 1930, to May 22, 1930, that I last saw him alive on May 22, 1930, and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Endo + Myo carditis

To my knowledge (duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Necropsy

(Signed) D. T. Mohn M. D.

5/27/30 (Address) 301 S Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL May 24 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

Spec.—1-30—M. & T.—250 Bkc.

E 57430 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 57430

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 7218 Brodlea Ave ST. 26-41 WARD)

2-FULL NAME Peter Schuppner

(a) RESIDENCE NO. 7218 Brodlea Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Schuppner

DATE OF BIRTH (month, day, and year) Jan 11 1865

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	4	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs Jennie Schuppner

(Address) 7218 Brodlea Ave

Filed 5-1 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1930

17 I HEREBY CERTIFY, That I attended deceased from January 22 1929 to May 22 1930, that I last saw him alive on May 22 1930, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arterial Hypertension

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia and Cardiac Dilatation (duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Typical Examination

(Signed) Attended Deceased M. D.

5/23 1930 (Address) 2025 E Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL May 26 1930

ADDRESS

UNDERTAKER John Ulrich

ADDRESS 2011 Orleans

Spec.—8-16-29—L. F. S.—100 Bks.

B 37052
B 57431

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10 E 57431

1—PLACE OF DEATH

REGISTERED NO. 27-54

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. OR WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gladys Hagberg

(a) RESIDENCE NO. 1809 Thornbury Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: B. L. Hagberg

6 DATE OF BIRTH (month, day, and year): May 24-1897

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	11	29	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: NW 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

8 BIRTHPLACE (city or town) (State or country): Atlantic Ocean

10 NAME OF FATHER: Henry McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country): Grenada

12 MAIDEN NAME OF MOTHER: Maud Willet

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Grenada

Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

Filed: 4 1930 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23-1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to May 23, 1930, that I last saw her alive on May 23, 1930 and that death occurred, on the date stated above, at 9 45 P.m.

The CAUSE OF DEATH* was as follows:

Brain abscess.

Otis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Opening for otitis abscess Date of May 15, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Howard C. Knapp, M. D.

(Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York N. Y.	May 27 1930
20 UNDERTAKER: Henry Hankins & Son	ADDRESS: Otis & Gold

Spec.—1-30—M. & T.—250 Blks.

E 57432

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57432

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) George Harding ST. 10-14 (WARD)

2-FULL NAME 1009 Sterling

(a) RESIDENCE NO. ..... ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Bessie

6 DATE OF BIRTH (month, day, and year) Feb. 29, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stable work

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

10 NAME OF FATHER Silas Harding

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Martha Gould

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

PARENTS

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22-30

17 I HEREBY CERTIFY, That I attended deceased from 5-16-30, 19..., to 5-22-30, 19...,

that I last saw him alive on 5-22-30, 19...,

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Pleuritis, Chronic

(duration) yrs. 4½ mos ..... ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

(duration) yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Warren H. McLean, M. D.

5-23, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL May 26, 1930

ADDRESS 1515 Fallsway

20 UNDERTAKER Payne Sander

Spec.—8-16-29—L. F. S.—100 3ks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57433

CERTIFICATE OF DEATH

+ 123 E.57433

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Miller

(a) RESIDENCE NO. Michigan Ave Balto Highlands Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Anton Miller

6 DATE OF BIRTH (month, day, and year) May 23, 1879

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	11	27	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER H H Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Mrs Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Rose Miller

(Address) Michigan Ave Balto Highlands Md.

15 Filed 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-21, 1930, to 5-22, 1930

that I last saw h... alive on 5-22, 1930

and that death occurred, on the date stated above, at 8.15 p. m.

The CAUSE OF DEATH* was as follows: Chronic Cholecystitis — Chronic Chole lithiasis C

Empyema of Gall Bladder

(duration) 17 yrs. mos. ds.

CONTRIBUTORY (Secondary) Surgical Shock Following Operation

(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5/22/30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M. C. Porterfield, M. D.

5/22, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A A Co	5/26 1930
20 UNDERTAKER Frederick A. Otz	ADDRESS 2000 Lombard

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57434

CERTIFICATE OF DEATH

129 E 57434

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 939 N. Dallas St., 7-13 Ward)

2-FULL NAME Wilson W. Brown

(a) RESIDENCE NO. 939 N. Dallas St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	Black	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of late Sarah Brown

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Musician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Joseph Barnett (Bro-in-law)
(Address) 939 N. Dallas St

15 Filed MAY 24 1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pneumonia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Chr Nephritis & Myocarditis (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Bauer, M. D.

5/24/30 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL 5-26 1930

20 UNDERTAKER Mrs Chas G. Bailey

ADDRESS 1421 Jefferson St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57435

CERTIFICATE OF DEATH

100-001 E 57435

REGISTERED NO. 24-22

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 Warren ave WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel V. May.

(a) RESIDENCE NO. 105 Warren Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Adeline W. May.

6 DATE OF BIRTH (month, day, and year) June 18 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer) Peters Shoe Store

(c) Name of employer 1039 S. Charles St Balto Md.

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Wm. H. May.

11 HIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Maria P. O'Dea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Irland

14 Informant Mrs Maria May

(Address) 105 Warren ave

15 Filed 19 C. HARRISON JONES, M. D. Registrar

24 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1929, to May 23, 1930, that I last saw him alive on May 22, 1930 and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Acute suppurative and Endocarditis following tonsillitis in aug 1929

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys + Lab

(Signed) Wm L Steffen, M. D.

5/24, 1930 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL May 26 30

20 UNDERTAKER F. A. Wannemacher

ADDRESS 703 Hanover St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57436 ✓ E 57436

CERTIFICATE OF DEATH

46

REGISTERED NO. 13-59

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Mae Pirie

(a) RESIDENCE NO. 2306 Druid Park Drive WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 8 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of George John Pirie

DATE OF BIRTH (month, day, and year) Sept. 14, 1886

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	8	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Charles Neale

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country) D.C.

12 MAIDEN NAME OF MOTHER Catherine Imhoff

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) D.C.

Informant George Charles Pirie

(Address) 2306 Druid Park drive

Filed MAY 24 1930 HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1930 to May 23, 1930

that I last saw her alive on May 23, 1930

and that death occurred, on the date stated above, at 2 33 P. m. (daylight saving time)

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ✓ yrs. ✓ mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of cervix.

(duration) ✓ yrs. 6 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Rudolph J. Schork M. D.

19 (Address) Womans Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL May 26 1930

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1946 W. Madison

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57437

CERTIFICATE OF DEATH

101 E 57437

E 57437

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 652 Josephine St., 4-25 Ward)

2-FULL NAME Ernest Syre

(a) RESIDENCE NO. 652 Josephine St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) March 19-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	1	2	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Syre

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mildred Barnes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md.

14 Informant Mildred Syre
(Address) 652 Josephine St

15 Filed ..19.. CHAMPION JONES M.D. Registrar

4 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

5/27 1930 (Address) 2139 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL 5/24 1930

20 UNDERTAKER Edmund A. Hensley ADDRESS 1138 Bolton

Spec.—8-16-29—L. F. S.—100 Bks.

E 57438

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57438

CERTIFICATE OF DEATH

REGISTERED NO. 1611

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Broadway ST. 25-77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Beddoe

(a) RESIDENCE NO. 1604 Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Infant

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) 5/21/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			17 hours	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Bigley Beddoe

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Frances Louise Kaiser

13 BIRTHPLACE OF MOTHER (city or town) Washington

(State or country) D. C.

14 Informant Mother

(Address) 1604 Broadway St

Filed MAY 24 1930, 19 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22/30

17 I HEREBY CERTIFY, That I attended deceased from 5/21/30, 19..., to 5/22/30, 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Prematurity -

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Alexandria Lowry, M. D.

, 19 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL MAY 23 1930

20 UNDERTAKER Commissioner of Health

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57439

E 57439

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr James Geraghty

(a) RESIDENCE NO. 1104 E. Biddle ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine E. Geraghty

7 DATE OF BIRTH (month, day, and year) May 5, 1860

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	0	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer Baltimore City.

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER John Geraghty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant James J. Geraghty

(Address) 1214 Edmondson Ave

Filed ..... 19 .....

C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/23/30

17 I HEREBY CERTIFY, That I attended deceased from 12/18, 1929 to 5/23, 1930,

that I last saw h.. alive on 5/23, 1930

and that death occurred, on the date stated above, at 11 55 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis generalized
Chronic myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Thos. E. Stacy Jr, M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 26, 1930
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	9242 E. Eager St.

Spec.—8-16-29—L. F. S.—100 Blks.

E 57440

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57440

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1048 W Barre St. 7-1-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Benzin

(a) RESIDENCE NO. 1048 W. Barre St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life time mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henrietta Benzin

6 DATE OF BIRTH (month, day, and year): Feby 14. 1862

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	3	9.	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Candy maker

(b) General nature of industry, business, or establishment in which employed (or employer): Same do

(c) Name of employer: —

8 BIRTHPLACE (city or town) (State or country): Balto City

10 NAME OF FATHER: Jno Benzin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmina Wilt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Blanche L. Benzin

(Address) 1048 W Barre St

Filed MAY 25 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May. 23. 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10 1930 to May 23 1930

that I last saw him alive on May 23 1930

and that death occurred, on the date stated above at 7.30 pm

The CAUSE OF DEATH* was as follows:

Carcinoma Oesophagus at Cardiac end of Stomach (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) duration indefinite (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? X Ray

(Signed) M L Friedinger M. D.

5 24 1930 (Address) 682 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western

DATE OF BURIAL: MAY 26 1930

20 UNDERTAKER: Leo N Little

ADDRESS 2700 EDMONDSON AVE.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57441

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 57441

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 W. Mt. Royal Ave. ST., 11-70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles H. Henry

(a) RESIDENCE NO. 127 W. Mt. Royal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mattie S. Henry

7 DATE OF BIRTH (month, day, and year) Feb 16, 1854

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER James A. Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant R. Harold Henry

(Address) Bengies Md

15 Filed ..... 19 ..... Registrar

MAY 25 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-23-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 18th, 1930, to May 23rd, 1930, that I last saw him alive on May 23rd, 1930 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(Duration) ... yrs. ... mos. 1 da.

CONTRIBUTORY (Secondary) Arterio-Sclerosis and Mitral Regurgitation (duration) 10 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Williams S. Hesbicht M. D.

. 19 (Address) 1700 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL MAY 26 1930

20 UNDERTAKER Geo W. Little

ADDRESS 2708 ERDMAN AVE

Spec.—2-29-28—L. F. S.—500 Bks.

E 57442 HEALTH DEPARTMENT—CITY OF BALTIMORE 89 E 57442

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 209 N Madison ST. 11-24 WARD)

2—FULL NAME Clara D. Williams

(a) RESIDENCE NO. 209 N. Madison ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of John G. Williams

DATE OF BIRTH (month, day, and year) March 12, 1864

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	2	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer At Home

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Claggett Dorsey

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Pinkerton

13 BIRTHPLACE OF MOTHER (city or town) Pinkerton (State or country)

Informant Olin D. Williams

(Address) 209 N Madison St

Filed ....., 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24-1930

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 24, 1930; that I last saw h[illegible] alive on May 23, 1930 and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Angina-Pectoris

From history - last (duration) yrs. 2 mos. + ds.

CONTRIBUTORY (Secondary) General Artery-Sclerosis - (duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) A. T. Robinson, M. D.

5/24, 1930 (Address) Medical Arts Building.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lucy Md

20 UNDERTAKER William Cook.

DATE OF BURIAL 5/26 1930

ADDRESS 1217 St Paul

Spec.—1-30—M. & T.—250 Blks

E 57443 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57443

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 N. Pulaski ST. 15-21 WARD)

2-FULL NAME John Kefpler

(a) RESIDENCE NO. 1907 N Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel

6 DATE OF BIRTH (month, day, and year) Feb 22 - 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	3 0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jacob Kefpler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Ethel Kefpler (Address) 1907 N Pulaski St

15 Filed ... 19 ... by ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1930, to May 24, 1930, that I last saw him alive on May 23, 1930, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular-Renal Disease

(duration) 2 yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Uremic Poisoning (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert C. Knapp, M. D.

5/24 1930 (Address) 1216 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL 5/27 1930

20 UNDERTAKER Wm Cook

ADDRESS 127 N Gould St

C. HARRY JONES, M.D.

MAY 25 1930

REGISTRAR

Spec.—1-30—M. & T.—250 Bks.

E 57444 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57444

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Monument & Rutland ST. 12-50 WARD

2-FULL NAME Jeanette Campbell

(a) RESIDENCE NO. Astor Court Apt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manicurist 086

(b) General nature of industry, business, or establishment in which employed (or employer) Barber

(c) Name of employer Caya Barber Shops Inc

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Bernard Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Francis Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs M. Behrend (Address) Calvert Building

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23-1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 23, 1930, that I last saw h alive on May 23, 1930, and that death occurred, on the date stated above, at 5.55 P m.

The CAUSE OF DEATH* was as follows:

Cardiac ~~failure~~ insufficiency
(aortic insufficiency)
(cardiac dilatation & hypertrophy)
Chronic myocarditis
(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Lab.

(Signed) H. H. Silver, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pen Cathedral — DATE OF BURIAL 6/26 1930

20 UNDERTAKER Wm Cook — ADDRESS 1219 E Pond St

Spec.—1-10-21—M&T—1500 Bks.

E 57445 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57445

CERTIFICATE OF DEATH. + 101

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No) Ms. Gen Hosp. ST. 11-24 WARD)

2-FULL NAME Lorence E Kholms

(a) RESIDENCE NO. Sparrows Pt. R.F.D #10 ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred ?? yrs. ... mos. 6 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug 28th 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	12	8	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Schoof
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS
10 NAME OF FATHER John Erholms
11 BIRTHPLACE OF FATHER (city or town) (State or country) Finland
12 MAIDEN NAME OF MOTHER Anna Lind
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Finland

14 Informant Hosp. Records
(Address)

15 Filed ... , 19 ... C. HAMPSON JOHNS, Registrar
By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-24-30 19

17 I HEREBY CERTIFY, That I attended deceased from 5-18-30 , 19 ... to 5-24-30 , 19 ... ,
that I last saw him alive on 5-24-30 , 19 ... ,
and that death occurred, on the date stated above, at 10:10 A.M. P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) ... yrs. ... mos 9 ds.
CONTRIBUTORY (Secondary) Peritonitis
(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of ...
Was there an autopsy? No Clinical
What test confirmed diagnosis?
(Signed) H.K. Vann, M. D.
, 19 (Address) Ms. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL 5/27/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul st

Spec.—1-30—M. & T.—250 Bks.

E 57446 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57446

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2302 Eadley ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Helen Pursley

(a) RESIDENCE NO. 2302 Eadley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of or) WIFE of James H. Pursley

6 DATE OF BIRTH (month, day, and year) Aug 13 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Ruth J Bulgrin.

(Address) 2302 Eadley St.

15 Filed ....., 19.. C. HAMPSON JONES

For Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22-1930

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1930, to May 22, 1930, that I last saw h.. alive on May 22, 1930, and that death occurred, on the date stated above, at 5 50 P m.

The CAUSE OF DEATH* was as follows:

Uraemic coma

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? W

What test confirmed diagnosis?

(Signed) M. L. Lichtenberg M. D.

5/23, 1930 (Address) 1717 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 5-26 1930

20 UNDERTAKER Bernard Hartz 1000

ADDRESS S Paca St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57447

E 57447

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Steer Calvert enroute to Baltimore St., Ward)

2-FULL NAME Latimer H. Phillips.

(a) RESIDENCE NO. Hebron Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Gertrude Phillips

6 DATE OF BIRTH (month, day and year) July 4. 1885.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	44	10	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Insurance Agent
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Marietta Md.
(State or country)

PARENTS

10 NAME OF FATHER Zachariah Phillips

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary E. Cannerly.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Mary E. Cooper (Sister)
(Address) Laurel Del.

15 Filed ....., 19.... C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1930

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency
Acute dilatation of the Heart

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? Hebron Md.

Did an operation precede death? No Date of

Was there an autopsy? No Inquest

What test confirmed diagnosis?

(Signed) Otto M. Reinhardt, M. D.

(Address) Otto M. Reinhardt May 24. 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sharptown Md. DATE OF BURIAL 5-26 1930

20 UNDERTAKER W. L. Graves ADDRESS Box Sharptown Md.

Important. See instructions on back of certificate.

5 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57448

CERTIFICATE OF DEATH

161-001 E 57448

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2227 Essex St., 1-3 Ward)

2-FULL NAME Arthur Gough

(a) RESIDENCE NO. 2227 Essex St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 29-1871

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	58	6	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Robt. H. Gough

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah E. Sullene

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Wm. H. Gough
(Address) 1173 S. Lakewood ave.

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MAY 25 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Suicide
Gas Poisoning I.H.
(duration) ....yrs. ....mos. — ds.
CONTRIBUTORY (Secondary) Asphyxia
(duration) ....yrs. ....mos. — ds.

18 Where was disease contracted — —
If not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? Yes History
What test confirmed diagnosis?
(Signed) G. C. Wades, M. D.
19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL May 26 1930

20 UNDERTAKER Wm. E. Black ADDRESS 927 N. Broadway

Important. See instructions on back of certificate.

Corp. 12-[illegible] 4 Qcc 200 Bks.

E 57449 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57449

CERTIFICATE OF DEATH. 185

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St. 14-28 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary I. Johnson

(a) RESIDENCE NO. 1513 Henry St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Johnson

6 DATE OF BIRTH (month, day, and year) Sept. 24 1849

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	80	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER Andrew Sims

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Jane Bone

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Mr. Johnson (son)

(Address) 1513 Henry St.

15 Filed [illegible] C. HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia-Concussion of Brain

Accidently fell down stairway at her home (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Cairns M. D. (Coroner)

5/24/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial May 26 1930

20 UNDERTAKER J. Fenw McCully ADDRESS 130 E. Fort

MAY 1930

Duplicate. See directions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 57450

E 57450 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital (St.) 13-54 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Goldblum

(a) RESIDENCE No. 3434 Auchentoroly Terrace (St.) (Ward)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Sarah Goldblum

6 DATE OF BIRTH (month, day, and year) Unknown —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Goldblum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Emanuel Goldblum

(Address) 3434 Auchentoroly Terrace

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22/30

17

I HEREBY CERTIFY, That I attended deceased from 5/21, 19 30 to 5/22, 19 30, that I last saw h[illegible] alive on 5/22, 19 30, and that death occurred, on the date stated above, at 4-4 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

- Intenual capsule (left)

(duration) 2 yrs. mos da.

CONTRIBUTORY (Secondary) Second attack Cerebral Hemorrhage (duration) yrs. mos. 24 hrs.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J J Cohn M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Levy Mem. Park

DATE OF BURIAL 5-25 1930

20 UNDERTAKER Jack Levin, 1439

ADDRESS Balto.

MAY 25 1930

Spec.—1-30—M. & T.—250 Blks.

E 57451

E 57451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St. 17-26 Ward)

2-FULL NAME Baby girl Hill

(a) RESIDENCE No. 629 N. Fremont Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Bernard Hill

11 BIRTHPLACE OF FATHER (city or town) Lithuania
(State or country)

12 MAIDEN NAME OF MOTHER Ruth Greenfield

13 BIRTHPLACE OF MOTHER (city or town) Lithuania
(State or country)

14 Informant Hosp. Records
(Address)

15 Filed ... 19 C. HAMPSON JONES, M. D. Registrar

2 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23-1930

17

I HEREBY CERTIFY, That I attended deceased from May 21, 1930, to May 23, 1930,

that I last saw h[illegible] alive on May 23, 1930,

and that death occurred, on the date stated above, at 7 45 a. m.

The CAUSE OF DEATH* was as follows:

Dr. Keyser

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Premature birth. Asphyxia

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob H. Coon, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. View Woodlawn — DATE OF BURIAL 5-25-1930

20 UNDERTAKER D. Jacob Reuss 1438 — ADDRESS Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57452

CERTIFICATE OF DEATH

139

E 57452

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) West Balto Gen Hosp St. 16-23 Ward

2-FULL NAME Edith Washington

(a) RESIDENCE No. 1203 Laurens St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fml	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer) 0'10
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER George Emory

11 BIRTHPLACE OF FATHER (city or town) Unk
(State or country)

12 MAIDEN NAME OF MOTHER Mary Turner

13 BIRTHPLACE OF MOTHER (city or town) Unk
(State or country)

14 Informant Nathaniel Emory
(Address) 1636 E. Eutaw

15 Filed ..... 19..... Registrar

C. HAMILTON JONES, M. D.

5/29/30

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21st 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Operative Pulmonary Embolism. Sudden (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fibroid Uterus. (duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of - May 21

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) F. B. Lynch, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL May 24 1930

20 UNDERTAKER Samuel Abernethy

ADDRESS 578 N. Eutaw

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 57453

E 57453 HEALTH DEPARTMENT—CITY OF BALTIMORE

33

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) President Hospital (18-26 WARD)

2-FULL NAME Isaac Taylor

(a) RESIDENCE NO. 207 N. Arlington Ave. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Taylor

6 DATE OF BIRTH (month, day, and year) (C.H.)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jobber

(b) General nature of industry, business, or establishment which employed (or employer) Tailors 050

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Florence Taylor (Address) 207 N. Arlington Ave

15 Filed MAY 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22-30

17 I HEREBY CERTIFY, That I attended deceased from 5-20-, 1930, to 5-22, 1930,

that I last saw h[illegible]ive on 5-22, 1930,

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Larynx
Intestinal Obstruction
Peritonitis

(duration) ..... yrs. ..... mos. 4 da.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 5/21/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Hamburger, M. D.

5/22/1930 (Address) 600 Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cem. DATE OF BURIAL 5/25 1930

20 UNDERTAKER Frank T. Hamburger & Sons ADDRESS 1818 Eddie

Spec.—2-29-28—L. F. S.—500 Bks.

E 57454 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57454

74-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. .....

CITY OF BALTIMORE: (No. 2641 Kirk ave ST., 9-46 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louisa M. Gallion

(a) RESIDENCE NO. 2641 Kirk Ave ST., ... WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of [illegible]

7 DATE OF BIRTH (month, day, and year) Dec 25-1851

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 0 3

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Frisch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER [illegible] Knauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm Gallion (Address) 2641 Kirk ave

15 Filed MAY 25 1930 G. HAMPSON JONES, M. D. Registrar By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1930

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930 to May 23, 1930, that I last saw h alive on May 22, 1930 and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Right Hemiplegia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and Gall Bladder disease (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? (Probably Cholecystitis)

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas Smith, M. D.

(Address) 47 N Hartford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 26 1930
UNDERTAKER Henry Lutz	ADDRESS 1203 N Broadway

Spec.—1-30—M. & T.—200 Blks

E 57455

E 57455

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. ..... ST. 3-52 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Smith

(a) RESIDENCE NO. 5648 Elsm Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella O. Smith

6 DATE OF BIRTH (month, day, and year) July 29 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	70	9	23	

8 OCCUPATION OF DECEASED 034

(a) Trade, profession or particular kind of work None Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 2 years

(c) Name of employer

9 BIRTHPLACE (city or town) Oakland (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) Hungerford (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Lilly

13 BIRTHPLACE OF MOTHER (city or town) Hungerford (State or country) Md.

14 Informant James A. Lowson (Address) 5648 Elsm Ave

15 Filed 25 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to May 22, 1930, that I last saw h. alive on May 22, 1930, and that death occurred, on the date stated above, at 11.39 P. m.

The CAUSE OF DEATH* was as follows:

Paralytic Hypostatic Pneumonia

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of May 19, 1930

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) K. I. Chuckrow, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	May 24, 30.
20 UNDERTAKER Horace A. Burgee	ADDRESS 363 Falls Road

Spec.—2-29-28—L. F. S.—500 Bks.

E 57456

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57456

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 265 S. East Ave (St.) 16-16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph W. Deckenar

(a) RESIDENCE NO. 265 S. East Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Deckenar

6 DATE OF BIRTH (month, day, and year) July 24 1878

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	9	29	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commissioner

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Joseph Deckenar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Annie Dugan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Lena Deckenar

(Address) 265 S. East ave

15 Filed MAY 25 1930, 19... C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22/30

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to May 22, 1930.

that I last saw h... alive on May 22, 1930

and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endo-Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Diffuse Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uranalysis etc

(Signed) Frank J. Ayd, M. D.

May 23, 1930 (Address) 2045 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	May 26 1930
20 UNDERTAKER	ADDRESS
William E. Schaffer	1816 Monument

Spec.—2-29-28—L. F. S.—500 Bks.

E 57457

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 57457

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 S. Ellwood Ave ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John C. Distler

(a) RESIDENCE NO. 3022 E Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed or divorced HUSBAND of (or) WIFE of Anna S. Distler

6 DATE OF BIRTH (month, day, and year) April 5, 1859

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	20	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Notary Public

(b) General nature of industry, business, or establishment in which employed (or employer) Public Service

(c) Name of employer Comm.

8 BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER Conard Distler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Distler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Distler

(Address) 3022 E. Balto St.

15 FILED MAY 25 1930 E. HAMBLETON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1927, to May 25, 1930, that I last saw h[illegible] alive on May 25, 1930 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Coronary Sclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 3022 E Baltimore

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Cardiograph Etc

(Signed) Edward J Coon, M. D.

5/25, 1930 (Address) 413 N Rooshington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery — DATE OF BURIAL May 28, 1930

20 UNDERTAKER John A. Moran — ADDRESS 3000 E. Balto St.

Cor.—10-10-29—A Co.—100 Bks.

E 57458

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57458

CERTIFICATE OF DEATH

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1216 Smithson St. (Ward) 16-23

2-FULL NAME Clarence Wardell Jr

(a) RESIDENCE NO. 216 Smithson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 6 1930

7 AGE: Years | Months: 2 | Days: 18 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Clarence Wardell
11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)
12 MAIDEN NAME OF MOTHER Carrie Anderson
13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Carrie Wardell
(Address) 216 Smithson St

15 Filed May 25 1930 19 HERMAN JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Was there any

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 5-26-30

20 UNDERTAKER Jones Corbin

ADDRESS 916 Pennsylvania

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57459

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-004

E 57459

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 12-44

CITY OF BALTIMORE: (No. 548 W. University Parkway WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lill F. Williams

(a) RESIDENCE NO. 548 W. University Parkway WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. - mos. - ds. How long in U. S., if foreign birth - - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ward D. Williams

6 DATE OF BIRTH (month, day, and year) Jan. 16, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward G. Fahnestock

11 BIRTHPLACE OF FATHER (city or town) -----

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Maria L. Tate

13 BIRTHPLACE OF MOTHER (city or town) ------

(State or country) Pennsylvania

14 Informant Mrs. Wilmer W. Wagner

(Address) 548 W. University Parkway

15 Filed MAY 25 1930 C. HARPER JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/24/30

17 I HEREBY CERTIFY, That I attended deceased from 5/1 - 1930, to 5/25 - 1930, that I last saw h[illegible] alive on 5/24 1930 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexia (Haemorrhage into Brain)

(duration) 1 yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Goldberg, M. D.

5/25, 1930 (Address) 2210 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 5/26 1930

20 UNDERTAKER Wm. D. Mears and Son

ADDRESS 805 N. Calvert

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57460 ✓ E 57460

E 57460

CERTIFICATE OF DEATH

185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Bladensdell bo. Boston St. (St.) 14-20 (Ward)

2-FULL NAME Vance M. Sutton

(a) RESIDENCE NO. 161 Gretaw St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Jewel Sutton

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: about 30 | Months: | Days: | IF LESS than 1 day ....hrs. or ....min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Brick Layer
(b) General nature of industry, business, or establishment in which employed (or employer): Oil
(c) Name of employer

9 BIRTHPLACE (city or town) N. C.
(State or country)

PARENTS

10 NAME OF FATHER: Philip Sutton

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER: Ethel Browning

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant: Rosa Allen Elwood
(Address) Wilmington N. C.

15 Filed ..... 19.... G. HERSON JONES, Registrar
MAY 25 1930 By ....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acc. Fall from Stack
Multiple Fractures
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

May 25 1930.

(Signed) W. C. Eades, M. D.

(Address) 1432 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wilmington N. C.

DATE OF BURIAL: 5/25/1930

20 UNDERTAKER: J. A. Moran

ADDRESS 300 E Broad St

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

235995
E 57461

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57461

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 7-9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Dillis

(a) RESIDENCE NO. Winchester Va ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Unknown

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Sept-27-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Frank Dillis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15 Filed 2-5 1930 19 C. HAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-25-1930

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1930, to May-25, 1930, that I last saw him alive on May 25, 1930, and that death occurred, on the date stated above, at 4.55 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, hypertension
myocardial insufficiency

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) Ludwig Kaerius, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winchester Va

DATE OF BURIAL 5-27 1930

UNDERTAKER R. T. Jones & Bro.

ADDRESS Winchester Va

Spec.—1-10-21—M&T—1500 Blks.

E 57462 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 57462

CERTIFICATE OF DEATH. + 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 11-30 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert W. Linthicum

(a) RESIDENCE NO. Sambrill, Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) .....

7 AGE — Years: 56 — Months: ..... — Days: ..... — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): House building

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Frederick Co.

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) (State or country) .....

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant: J. Wm. Williams
(Address) .....

15 Filed MAY 29 1930, 19 — C. HAMPSON JONES, M.D. — Registrar: E.H.G.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/25 19 30

17 I HEREBY CERTIFY, That I attended deceased from 5/19, 19 30, to 5/25, 19 30,

that I last saw him alive on 5/25, 19 30,

and that death occurred, on the date stated above, at 6:10 P.m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of Prostate gland and Chronic Nephritis

(duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Urinary Retention

Uremia (duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Luther C. Little, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Glenwood Md — DATE OF BURIAL: May 27, 1930

20 UNDERTAKER: E. Asa Williams — ADDRESS: Woodbine Md

IT IS very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57463 HEALTH DEPARTMENT—CITY OF BALTIMORE 8 VE 57463

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 1755

CITY OF BALTIMORE: (No. 3621 Glenguyle Road)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis B. Bernai

(a) RESIDENCE NO. 3621 Glenguyle Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 15, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney

(b) General nature of industry, business, or establishment in which employed (or employer) own

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Seligman Bernai

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Steinhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas. Austrian (Address) 1417 Eutaw Place

15 Filed MAY 26 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1926, to May 23, 1930, that I last saw him alive on May 24, 1930 and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis Myocardial degeneration

Angina pectoris

(duration) + yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & physical signs

(Signed) Charles F. Bernai, M. D.

5/24/1930 (Address) 1417 Eutaw Place Austrian

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chebt Shalom Cem.

DATE OF BURIAL 5/26/1930

20 UNDERTAKER Hurd Sondheim

ADDRESS 1820 W. Mt. Royal Ave

Spec.—1-12-23—M&T—500 Bks.

E 57464 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57464

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Jenkins Memorial ST., (Dept. or WARD)

2-FULL NAME Elizabeth M. Levy.

(a) RESIDENCE NO. Brookfield Ave & Whitelock St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Levy.

6 DATE OF BIRTH (month, day, and year) Feby 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	70	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond Va (State or country)

PARENTS

10 NAME OF FATHER Albert Meyer

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Dr. A. J. Levy (Address) 800 E. Preston St

15 Filed ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby, 1929 to May 25 1930, that I last saw h[er] alive on May 25 1930, and that death occurred, on the date stated above, at 10[10] P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert A. Levy, M. D.

5/26/30 (Address) 800 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond, Va. DATE OF BURIAL 5/27/1930

20 UNDERTAKER Harrid Sandheim ADDRESS 118-20 W. Mt. Royal Ave

MY 28 1930 KD

Cor.—10-10-29—A Co.—100 Bks.

Otis S. Crockett.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57465 ✓ E 57465

E 57465

CERTIFICATE OF DEATH

159-004

1-PLACE OF DEATH

City of Baltimore: (No. 415 Furman St., 20-69 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otis S Crockett

(a) RESIDENCE NO. 415 Furman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54a yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
		5	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Edgar L. Crockett

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Blanch E. Sherwood

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Edgar L Crockett
(Address) 415 Furman

15 Filed ..., 19... C. HAMPSON JONES Registrar
MAY 26 1930 Mar

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brownback, M. D.

May 24 19 30 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	5/26 1930
20 UNDERTAKER Freeman Cook	ADDRESS 1217 St Paul

Cor.—10-10-29—A Co.—100 Bks.

E 57466

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57466

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4734 Frederick Ave. 28-71 Ward)

2-FULL NAME Wm. C. Moore

(a) RESIDENCE NO. Atlanta Ga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice E Moore

6 DATE OF BIRTH (month, day, and year) Mar 16 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
M	52	2	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Auditor So R R Co
(b) General nature of industry, business, or establishment in which employed (or employer) Ry
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Christopher Moore

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs Alice E Moore
(Address) Atlanta Ga.

15 Filed ..... 19.. C. HARRISON JONES, M. D. Registrar

JE 6 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'Donnell Broome, M. D.

5/24. 1930 (Address) 3601 3rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fort Lincoln, Md.

DATE OF BURIAL 5/26 1930

20 UNDERTAKER Harry N. Witzke, 4101

ADDRESS Edmondson Ave

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 57467 HEALTH DEPARTMENT—CITY OF BALTIMORE 1001 E 57467

E 57467 CERTIFICATE OF DEATH. 100

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST. 4 30 WARD)

2-FULL NAME Thomas Bowyer

(a) RESIDENCE NO. West River ST., Md WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/21/20

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Going School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dalesville Md

PARENTS

10 NAME OF FATHER Walter Bowyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) U S A

12 MAIDEN NAME OF MOTHER Elsie Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.A.

14 Informant Joseph Mabell
(Address)

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-25-30 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-20-, 1930, to 5-25, 1930, that I last saw him alive on 5-24-30, 1930 and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
Staph Meningitis
Septicaemia
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. B. Johnson, M. D.

May 19 30 (Address) Union Mem

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dalesville

DATE OF BURIAL May 30 1930

20 UNDERTAKER H. A. Hawksley

ADDRESS Dalesville Md

Spec.—1-30—M. & T.—250 Bks

E 57468 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 57468

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1426-E. Lanvale ST., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha W. Dyott

(a) RESIDENCE NO. 1426-E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Dyott

6 DATE OF BIRTH (month, day, and year) 10/16/1856

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	73	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbott Co. Md

PARENTS

10 NAME OF FATHER Thos. Fairbanks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rebecca Fairbanks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Aaron Dyott

(Address) 1238 Harford Ave

15 Filed MAY 26 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 22, 1930,

that I last saw h alive on May 21, 1930,

and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Simms, M. D.

5/22 1930 (Address) 4706 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem.

DATE OF BURIAL 5/26/1930

20 UNDERTAKER Mary T. Ruth

ADDRESS 1730 Harford Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57469 101-001 E 57469

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE; (No.) 2716 Fox ST. 12-51 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Doris Smallwood

(a) RESIDENCE NO. 2716 Fox ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 8-1925

7 AGE: Years 4 | Months 11 | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Wallis E. Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Fannie P. Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Fannie P. Smallwood (Address) 2716 Fox St

15 Filed [illegible] 1930 C. HAMPSON JONES Registrar

MAY 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to May 24, 1930,

that I last saw h er alive on May 24, 1930

and that death occurred, on the date stated above, at 9:20 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) [illegible], M. D.

5/25. 1930 (Address) 2020 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: May 26 1930

20 UNDERTAKER: A S Marshall 3539 — ADDRESS: Fall Road

Spec.—2-29-28—L. F. S.—500 Blks.

E 57470

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

162 E 57470

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1109 S. Bouldin ST. 76-1 WARD)

2—FULL NAME Baby Girl Gorge

(a) RESIDENCE NO. 1109 S. Bouldin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 26-1930

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or 1 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John W. Gorge

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret Eddeman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md.

14 Informant John W. Gorge
(Address) 1109 S. Bouldin

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25/30.

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1930, to May 25, 1930, that I last saw her alive on May 25, 1930, and that death occurred, on the date stated above, at 5:50 A. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No: Date of

Was there an autopsy? No:

What test confirmed diagnosis?

(Signed) Dudley F. Bowie, M. D.

5/25. 1930 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland Cem	May 26 1930
20 UNDERTAKER	ADDRESS
George W. Zirkle	1737 E. Eager

Cor.—10-10-29—A Co.—100 Bks.

E 57471

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

165 E 57471

1-PLACE OF DEATH

City of Baltimore: (No.) St. Joseph Hospital St. 27-45 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Corns

(a) RESIDENCE NO. 4218 Belair Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Clara F. Corns

6 DATE OF BIRTH (month, day, and year) July 5/1874

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	55	10	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pharmacist
(b) General nature of industry, business, or establishment in which employed (or employer) Pharmacist
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER A E. Corns

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Hester Bouldin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Clara F. Corns
(Address) 4218 Belair Road

15 Filed MAY 26 1930 19 C. HARRY JONES II Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cyanide Potassium Poisoning

Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

5/25/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	May 27 1930
20 UNDERTAKER	ADDRESS
George W. Zirkler	1737 E. Eager

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57472

E 57472

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 Holbrook ST., 9-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Hammann

(a) RESIDENCE NO. 1405 Holbrook ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. — mos. — ds. How long in U. S., if of foreign birth? 46 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Josephine Hammann

6 DATE OF BIRTH (month, day, and year) Jan. 21 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of Industry, business, or establishment in which employed (or employer) Church

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Hammann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Josephine Hammann

(Address) 1405 Holbrook

C. HAMPSON GORES, M.

15 Filed 2-6 1930 By ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31st, 1930, to May 24th, 1930, that I last saw him alive on May 24th, 1930, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of Liver

(duration) about yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Alex. D. Weinstock, M. D.

5/29, 1930 (Address) 713 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 27 1930.
UNDERTAKER	ADDRESS
Henry Hoeck & Sons Inc	1301 E. Eager St

Cor.—10-10-29—A Co.—100 Bks.

E 57473

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 57473

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. No. 133 N. Front St. St. 5-8 Ward)

2-FULL NAME Sister Mary Honorata Sweeney, O. S. F.

(a) RESIDENCE NO. No. 133 N. Front St. St., _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. – mos. – ds. How long in U. S., if of foreign birth 33 yrs. – mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	51	–	–	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Religious Sister
(b) General nature of industry, business, or establishment in which employed (or employer) Order Of St. Francis
(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) Ireland

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Ireland

14 Informant Sr. Superiors
(Address) St. Vincents Convent
No. 133 N. Front St.

15 Filed _____, 19____ C. HANSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-24-1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Duration ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

Duration ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. J. Riley Coroner, M. D.

May 25 1930 (Address) 1659 Druid Park Drive

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL May 27 1930

20 UNDERTAKER Henry Hoeck Sons, Inc.

ADDRESS 1301 E Eager St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57474

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57474

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2924 Harlem Av. ST. 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick W. Luth

(a) RESIDENCE NO. 2924 Harlem Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 5 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida M. Snyder

6 DATE OF BIRTH (month, day, and year) Dec. 19-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Mens Clothing

(c) Name of employer Robinson Bros.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Luth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elma D. Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ida M. Luth

(Address) 2924 Harlem ave

15 Filed NOV 26 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25-1930

17 I HEREBY CERTIFY, That I attended deceased from May 15. 1930, to May 25 1930

that I last saw h alive on May 25 1930

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm D. Bebert M. D.

May 26 1930 (Address) 475 W Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL May 27 1930

20 UNDERTAKER Harry W. O'Leary

ADDRESS 1944 W. North Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57475

E 57475

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1031 Plum Al. St., 23-31 (Ward)

2-FULL NAME Leola Stewart C.

(a) RESIDENCE NO. 1031 Plum Al St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 6-1926

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
✓	3	7	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER William Stewart

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ida Simms

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Ida Stewart Mother
(Address) 1031 Plum Al

15 Filed ..., 19.. C. HAMPSON JONES M.D. Registrar

NOV 26 1930

Ref

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23- 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Rachitis

(duration) yrs. 4 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inquiry

(Signed) Otto Leinhardt, M. D.

May 24 1930 (Address) 1017 St Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[redacted] Forest	May 26 1930
20 UNDERTAKER	ADDRESS
H. L. Brown & Son	108 N. Mary

IMPORTANT—In plain terms, so that it may be properly classified. Each statement of occupation is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 57476

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57476

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH Jenkins Memorial Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1000 Caton Ave ST. [illegible] WARD 29

2-FULL NAME Florence J. Otworth

(a) RESIDENCE NO. 913 Hollins St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 1 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	7 1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Daniel F. Otworth

11 BIRTHPLACE OF FATHER (city or town) Altoona
(State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah V. Cragon

13 BIRTHPLACE OF MOTHER (city or town) Washington
(State or country) D. C.

14 Informant (Address) Jenkins Memorial Hospital 1000 Caton Ave

Filed MAY 26 1930 C. HARDSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-18, 1927, to 5-25, 1930, that I last saw her alive on 5-25, 1930, and that death occurred, on the date stated above, at 12-35 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic endocarditis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) George Brems, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary Evans | DATE OF BURIAL 5/28/30

UNDERTAKER Emge & Embry | ADDRESS Fulton & Fayette

Spec.—1-30—M. & T.—250 Bks. Handy Loftus E 57477

E 57477

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 14-20 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Handy Loftus

(a) RESIDENCE NO. 1634 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary Jane

6 DATE OF BIRTH (month, day, and year) Oct. 2, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	55	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Jennie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Records of (Address) Balto. City Hospitals.

15 Filed JUN 6 1930 19 per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-23-30

17 I HEREBY CERTIFY, That I attended deceased from 5-19-30, 19..., to 5-23-30, 19..., that I last saw him alive on 5-23-30, 19..., and that death occurred, on the date stated above, at 8:25 A.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Hypertension over 5 mos. ds.

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry M. McClean, M. D.

5-23, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL May 26 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1691 Orleans st

Spec.—1-30—M. & T.—250 Blks.

E 57478 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57478

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 16-23 WARD)

2-FULL NAME Katie Burkhart

(a) RESIDENCE NO. 722 N. Carey St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1864 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Anderson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ohio

12 MAIDEN NAME OF MOTHER [redacted] ? Forrester

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant .....
(Address) B. C. H.

Filed 2 6 1930, 19 ..... C. HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-24-30

17 I HEREBY CERTIFY, That I attended deceased from 8-2-29, 19..., to 5-24-30, 19..., that I last saw her alive on 5-24-30, 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ... yrs. 8 mos ... ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ... yrs. 8 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

5-24 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Ky

DATE OF BURIAL 5-26 1930

20 UNDERTAKER W. O. Welch

ADDRESS Fundship

Spec.—1-30—M. & T.—250 Bks.

E 57479 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 57479

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO. ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert L. Moore

(a) RESIDENCE NO. 2425 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Nannie Moore

6 DATE OF BIRTH (month, day, and year) 6/0 1862?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67.	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER Thomas Moore

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Sutton

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Va.

14 BALTIMORE CITY HOSPITALS Informant (Address)

15 Filed 2 6 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-24-30

17 I HEREBY CERTIFY, That I attended deceased from 5-2, 1929, to 5-24, 1930,

that I last saw him alive on 5-24, 1930,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

over 1 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

over 1 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

5-24, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester Co Va

DATE OF BURIAL May 26, 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57480

CERTIFICATE OF DEATH

E 57480

REGISTERED NO. 13/L

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. 2124 St Paul ST., 19-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline Blackford Adams

(a) RESIDENCE NO. 2124 St Paul ST., 19 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if foreign birth? 72 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Frank B. Adams

6 DATE OF BIRTH (month, day, and year) March-1858

7 AGE Years 72 | Months ? | Days ? | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Parkersburg W. Va.

PARENTS

10 NAME OF FATHER Thos Blackford

11 BIRTHPLACE OF FATHER (city or town) Parkersburg (State or country) Va.

12 MAIDEN NAME OF MOTHER Harriet Murdock

13 BIRTHPLACE OF MOTHER (city or town) Parkersburg (State or country) W. Va.

14 Informant Mr. Frank B. Adams (son) (Address) 7- South St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1926, to May 23rd 1930 that I last saw her alive on May 23rd 1930 and that death occurred, on the date stated above, at 11.45 m. S.T.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation

Terminal hypostatic

pneumonia (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Hypertension

Pyelitis (duration) 2+ yrs. + mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical diagnosis

(Signed) Nathaniel M Beck M. D.

19 (Address) 1004 E. 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL May 26 1930

20 UNDERTAKER Stewart & Mosner Co. — ADDRESS Balto.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57481 E 57481

CERTIFICATE OF DEATH.

118-001

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital 16-22 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... St., ... WARD)

2-FULL NAME Herman Charles Rednar

(a) RESIDENCE NO. 1106 N. Monroe ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Margaret Rednar

6 DATE OF BIRTH (month, day, and year) Sept 27-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	7 8	24 30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Private life

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Max Rednar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte Dominguez

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital records (Address)

15 Filed 2 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/26/30

17 I HEREBY CERTIFY, That I attended deceased from 5/15, 1930, to 5/26, 1930, that I last saw him alive on 5/26, 1930, and that death occurred, on the date stated above, at 8 40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism

(duration) ..... yrs. ..... mos 30 min. ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 5/16/30

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Wm N. McFaul Jr. M. D.

5/26, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 5/28/1930

20 UNDERTAKER Stewart & Company — ADDRESS Balto.

Spec.—1-30—M. & T.—250 Bks.

E 57482

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57482

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1009 Light St. WARD 24-33

2-FULL NAME Frank L. Wamhoff

(a) RESIDENCE NO. 1009 Light St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Wamhoff

6 DATE OF BIRTH (month, day, and year) Dec 10, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Tobacco Co Balt Md

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant Mary A. Wamhoff (Address) 1009 Light St.

15 Filed May 26 1930 19 C. Howard Jones, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 30

17 I HEREBY CERTIFY, That I attended deceased from May 23 30, 19..., to May 25 30, 19...,

that I last saw h— alive on May 25 30, 19...,

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Hist

(duration) yr. mos 5 ds.

CONTRIBUTORY (Secondary) Heart Lesion Mitral Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos B Hall, M. D.

May 25/30 (Address) 1023 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL May 28 1930

20 UNDERTAKER E. Howard Evans ADDRESS E Hatton

Spec.—1-30—M. & T.—250 Blks.

E 57483

E 57483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1514 Ropland ST. 25-77 WARD)

2-FULL NAME Peter Finger.

(a) RESIDENCE NO. 1514 Ropland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Finger.

6 DATE OF BIRTH (month, day, and year) July 28 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72.	9.	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter. 050

(b) General nature of industry, business, or establishment in which employed (or employer) retired 10 yrs.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Dont Know.

11 BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Margaret Marsh.
(Address) 1514 Ropland St.

15 Filed MAY 29 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1930, 19..... to May 25, 1930 19.....

that I last saw h.. alive on May 20, 1930, 19.....

and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? St Louis, Mo.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis .....

(Signed) Wm. D. Scott, M. D.

May 25 19 30 (Address) 4815 Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Louis Mo May 26, 1930

DATE OF BURIAL

UNDERTAKER H. Howard Evans

ADDRESS 38 E. Fort Ave

Spec.—1-30—M. & T.—250 Bks.

E 57484

E 37483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B-4 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

2-FULL NAME Lillian Bennett

(a) RESIDENCE NO. 1515 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	Black	child

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 18-1930

7 AGE Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edward Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bernice Galvin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fla

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

Filed MAY 26 1930 H. C. HAUSER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24-1930

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1930, to May 24, 1930, that I last saw her alive on May 24, 1930, and that death occurred, on the date stated above, at 1 A.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia (primary)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) J. V. Buckford, M. D.

5/24, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashury Cem

DATE OF BURIAL May 26, 1930

20 UNDERTAKER Mendel & Appel

ADDRESS 300 E Eden

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 57485 ✓ E 57485

90

REGISTERED NO.....

1-PLACE OF DEATH 4013 Wilsby Ave

CITY OF BALTIMORE: (No. 4013 ST. 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Michael Rippler

(a) RESIDENCE NO. 4013 Wilsby Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Agnes L. Rippler

6 DATE OF BIRTH (month, day, and year) April 21 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager 009

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery-store

(c) Name of employer A & P.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Wm. Rippler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Johanna Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Agnes Rippler (Address) 4013 Wilsby Ave

15 Filed MAY 28 1930, 19 HAROLD R. [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1929, to May 24, 1930, that I last saw h[illegible] alive on May 23, 1930, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) myocarditis, mitral insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) L. C. Sobieski M. D.

5/24 1930 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL May 27 1930

20 UNDERTAKER John A. Inman

ADDRESS 3000 E. Balt St.

ATTENTION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57486 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57486

90

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 S East ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Conrad Bohle

(a) RESIDENCE NO. 510 S East ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M Bohle

6 DATE OF BIRTH (month, day, and year) June 13 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
60	61	—	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Charles Bohle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cathrine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna M Bohle (Address) 510 S East ave

15 Filed 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 30

17 I HEREBY CERTIFY, That I attended deceased from Mar 16, 1930, to May 24, 1930; that I last saw h... alive on May 24, 1930, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Asth Pulm Edema

Chr myocarditis (duration) + yrs. mos. / ds.

CONTRIBUTORY (Secondary) Uremia - Hyp acid Nephritis (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? /

What test confirmed diagnosis?

(Signed) Argus S. Tuttle, M. D.

5/25, 1930 (Address) 533 S Ballast

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Swartz Gen

DATE OF BURIAL May 27 1930

ADDRESS

20 UNDERTAKER M. W. & Dippelbm 32 Lomb

Spec.—1-12-23—M&T—500 Bks.

E 57487

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57487

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kalunskas

(a) RESIDENCE NO. 677 W. Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Kalunskas

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Blanche Kalunskas (Address) 677 W. Barre St.

15 Filed MAY 26 1930 19 Howard Jones, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-25 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-25, 1930, to 5-25, 1930, that I last saw h.. alive on 5-25, 1930, and that death occurred, on the date stated above, at 4.50 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation

Chronic nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs

(Signed) Lewis P. Tuntley, M. D.

May 26th 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Russian Independent Cem. DATE OF BURIAL May 28 1930

20 UNDERTAKER Edw. Boettinger ADDRESS 423 S. Paca St.

Stock—12-23-21—E.B.R.S.—400 Blks.

E 57488

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57488

CERTIFICATE OF DEATH.

24-001

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1834 Ramsey St., 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George M. Miller

(a) Residence No. 1834 Ramsey St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Miller

6-DATE OF BIRTH (month, day and year) Feb. 6, 1873

7-AGE.	If LESS than 1 day,
57 yrs. 3 mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter employed at B & O R.R. shops

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: Frank Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Teresa Miller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) Mary A. Miller

(Address) 1834 Ramsey st

15- Filed ..... 193.. Registrar.

C. HAMPSON JONES, M. D.

2 6 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 25, 1930

17- I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to May 18, 1930

that I last saw h/ alive on May 18, 1930

and that death occurred, on the date stated above, at 12 40 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. ....dy.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(Duration) ....yrs. 3 mos. ....ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Personal observation

(Signed) Wm. Carnaden Bode, M. D.

, 19 (Address) 19 W. Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral	5/28/30
20-UNDERTAKER.	ADDRESS
Frank A. Cole	1200 N. Fremont Ave

Instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 57489 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57489

38

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 22-31 ST. (AVE.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Wheeler

(a) RESIDENCE NO. 137 W. Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Sadie Wheeler

6 DATE OF BIRTH (month, day, and year) Dec. 3, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frankford

(State or country) Ky.

PARENTS

10 NAME OF FATHER Sam Wheeler

11 BIRTHPLACE OF FATHER (city or town) Ky.

(State or country)

12 MAIDEN NAME OF MOTHER Lizzie Dudley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ky.

14 Informant Records of JOHNS HOPKINS HOSPITAL

(Address) Balto. City Hosp.

Filed 6-26 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-21-30

17 I HEREBY CERTIFY, That I attended deceased from 4-7-30, 19..., to 5-21-30, 19...,

that I last saw h... alive on 5-21-30, 19...,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis, tertiary

(duration) over 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) Aneurysm of Abdominal Aorta

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical: Wa R

(Signed) Marvin M. McLean, M. D.

5-22, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL MAY 26 1930

20 UNDERTAKER Commissioner Health.

ADDRESS

T. & W. WOODALL

Spec.—1-30—M. & T.—250 Bks.

E 57490 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57490

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 19-29 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Billups

(a) RESIDENCE NO. 515 S. Calhoun ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Louis Billups

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Julia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of
(Address) Balto. City Hospitals

15 Filed ..... 19 .....

C. HAMPSON JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22-30

17 I HEREBY CERTIFY, That I attended deceased from 8-28-29, 19..., to 5-22-30, 19...,

that I last saw him alive on 5-22-30, 19...,

and that death occurred, on the date stated above, at 11:31 A m.

The CAUSE OF DEATH* was as follows:

Arsenic Dermatitis

Myocarditis, Chronic

(duration) ..... yrs. 10 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? Home & here

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

5-23 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

MAY 26 1930

Spec.—2-29-28—L. F. S.—500 Rks.

E 57491

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

99-60 E 57491

1—PLACE OF DEATH

REGISTERED NO. 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Homewood Apts ST. 1 WARD)

2—FULL NAME Anne Fowler Maddox

(a) RESIDENCE NO. Homewood Apts Charles 33rd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28, 1847

7 AGE: Years 82 | Months 7 | Days 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fred Co Md

PARENTS

10 NAME OF FATHER Dr. Thomas N. Maddox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mary's Co Md

12 MAIDEN NAME OF MOTHER Mary P. Claggett

13 BIRTHPLACE OF MOTHER (city or town) Rockville (State or country) Md

14 Informant Mrs. Richard C. Williams

(Address) 3423 N. Calvert St.

15 Filed 2 6 1930 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/4, 1930, to 5/25, 1930, that I last saw h 21 alive on 5/25/1930 and that death occurred, on the date stated above, at 9:25 P. m.

The CAUSE OF DEATH* was as follows:

Bronchiectasis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Bacteroscopic findings

(Signed) Hebb Gebhart M. D.

(Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marks Cemy Wash. Co. Md.

DATE OF BURIAL: May 27, 1930

20 UNDERTAKER: Edw. O. Mitchell & Son

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

George Strouse

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57492

CERTIFICATE OF DEATH

90

E 57492

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Pronounced dead at Franklyn St., 1530 Ward)

2-FULL NAME George Strauss

(a) RESIDENCE NO. 1530 N. Stricker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
58	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) 045
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Geo. Strauss

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Susan Snaad

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Miss Rose Strauss
(Address) 1530 N. Stricker

26 1930 19 HAMILTON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O'B. Woodlee, M. D.

May 25. 1930 (Address) 3601 3rd W

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	May 28 1930
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1947 W. Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57493 ✓ E 57493

CERTIFICATE OF DEATH

129

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1735 Druid Hill Ave ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Toney

(a) RESIDENCE NO. 1735 Druid Hill Ave ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 070

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Bray

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant William Roney
(Address) 358 N Biddle St

15 Filed 2 6 1930 C. HAMPSON JONES, M. D. Registrar
Rpt

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/24/30

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1930, to May 24, 1930, that I last saw h[illegible] alive on May 24, 1930 and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Paranchymatous Nephritis (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardio-vascular Disease (duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) D. H. McCard, M. D.

5/26, 1930 (Address) 2029 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Antumn Cmty	5-27 1930
20 UNDERTAKER George T. McGibbon	ADDRESS 1735 Druid Hill Ave

Spec.—1-30—M. & T.—250 Bks.

E 57494 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57494

CERTIFICATE OF DEATH.

84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2612 E Chase ST. 8-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Duany

(a) RESIDENCE NO. 2612 E Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Marie Karl

6 DATE OF BIRTH (month, day, and year) May 16th 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Beth. Steel Co.

9 BIRTHPLACE (city or town) (State or country) Cuba

PARENTS

10 NAME OF FATHER Andres Duany

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cuba

12 MAIDEN NAME OF MOTHER Carmin Portona

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cuba

14 Informant Marie Karl Duany (Address) 2612 E. Chase St.

15 Filed ....., 19.... Registrar C. HAMPSON JONES, M. D.

6 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 24th 11 a.m., 1930, to May 24th 1h p.m., 1930, that I last saw him alive on May 24th, 1930, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris (2nd attack)

1st attack 2 weeks ago

2 years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edgar Engelhardt, M. D.

19 (Address) 304 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL 5/27/ 1930

20 UNDERTAKER E. J. Fleming

ADDRESS 1938 E. Lafayette Ave

Spec.—1-30—M. & T.—250 Blks.

E 57495 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 57495

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline Odonnell ST. 27 41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel L. Murray

(a) RESIDENCE NO. 4515 Harford Rd. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Beatrice W Murray

6 DATE OF BIRTH (month, day, and year) May 26th 1930

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer Eve Room Co

9 BIRTHPLACE (city or town) Montgomery Co (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant C. H. Timanus

(Address) 4515 Harford Rd

15 Filed 5-26 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-26-30

17 I HEREBY CERTIFY, That I attended deceased from 5-24, 1930, to 5-26, 1930, that I last saw h(e)r alive on 5-26, 1930, and that death occurred, on the date stated above, at 9.05 a.m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of Prostate

(duration) yrs. 6 mos da.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL 5/29/ 1930

UNDERTAKER D. Wm Cook

ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

E 57496

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 57496

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 240 N Monroe ST. W-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Tyler Cummings

(a) RESIDENCE NO 240 N Monroe ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	MARRIED

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma O. Cummings

6 DATE OF BIRTH (month, day, and year) July 31 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71	70	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Band Master

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

9 BIRTHPLACE (city or town) Franklinville
(State or country) New York.

PARENTS

10 NAME OF FATHER John Tyler

11 BIRTHPLACE OF FATHER (city or town) Elmira
(State or country) New York.

12 MAIDEN NAME OF MOTHER Julia

13 BIRTHPLACE OF MOTHER (city or town) Elmira
(State or country) New York.

14 Informant Emma O. Cummings
(Address) 240 N Monroe st

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24-30

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to May 24, 1930,
that I last saw h alive on May 24, 1930
and that death occurred, on the date stated above, at 7.50 P m.

The CAUSE OF DEATH* was as follows:

Uremia Toxemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) ch. Nephritis

(duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bey Owens, M. D.

May 24 1930 (Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL 5/27 1930

UNDERTAKER Townsend

ADDRESS 1217 St Paul st

C. HAMPSON JONES, M.

Spec.—1-30—M. & T.—250 Blks.

E 57497 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57497

CERTIFICATE OF DEATH.

60-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (NO. 27-48 ST. WARD

2-FULL NAME Jennie W. Rake

(a) RESIDENCE NO. 531 Tunbridge Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Herman W. Rake

6 DATE OF BIRTH (month, day, and year) July 30-1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER George Wm Horhall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mrs Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Herman W. Rake

(Address) 531 Tunbridge Rd.

15 Filed ....., 19 1934 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/24/30, 19..... to 5/25/30, 19.30., that I last saw her alive on 5/24/30, 19....., and that death occurred, on the date stated above, at 12 05 P m.

The CAUSE OF DEATH* was as follows:

(1) Diffuse Goitre Hyperthyroidism

(duration) 3 yrs. ? mos ..... da.

CONTRIBUTORY (Secondary) (1) Arteriosclerosis - (2) Embolism - momentary

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 24, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? History clinical Operation findings

(Signed) (1) Hyman, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem. May

DATE OF BURIAL 28 1930

20 UNDERTAKER John C. Miller 2435 E

ADDRESS Oliver

FROM A VERY IMPORTANT: See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57498

CERTIFICATE OF DEATH.

185 E 57498

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hosp., 1-1 Ward)

2-FULL NAME James C. Wilfong

(a) RESIDENCE NO. 2929 Fait Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 26 1853

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	77	0	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country) Randolf County Va.

PARENTS

10 NAME OF FATHER Jacub Wilfong

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) West Virginia

14 Informant Mathew Kaminski

(Address) 2929 Fait Ave

Filed 5-28 1930 C. HAMPSON JONES, M. D. Registrar

By _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

ACC Fall in home

Fracture of Leg

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

Broncho Pneumonia

(Duration) yrs. mos. 1 ds.

May 26 1930 (Signed) H. C. Coles M. D.

(Coroner)

(Address) 1430 N Gay

, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. Date of Burial May 28 1930

20 UNDERTAKER John M. Weber ADDRESS 101 E. Chester St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2 8 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57499 ✓ E 57499

CERTIFICATE OF DEATH

E 57499

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1031 E. Oliver St., 8-17 (Ward)

2-FULL NAME Celinda Sutton

(a) RESIDENCE NO. New Freedom, Pa. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 26 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Sutton

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
about 82			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work. Household Duties
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) York Co., Pa.

PARENTS

10 NAME OF FATHER Jacob Nonemaker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Penna.

12 MAIDEN NAME OF MOTHER Lydia Ehrhart

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Penna

14 Informant Louis M. Weedon
(Address) 1031 E. Oliver St.

15 Filed 6 1930 By C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Myocardial Insuffiviency- Accidently fell on coal stove & burned & scalded her righthand.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at her home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

5/26/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Freedom York Co Pa

DATE OF BURIAL May 29 1930

20 UNDERTAKER Warfenstein & Nonemaker

ADDRESS New Freedom Md

Spec.—8-16-29—L. F. S.—100 Bks.

E 57500 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 74-001 E 57500

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 S Wolf ST., 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Lesny

(a) RESIDENCE NO. 604 S Linwood Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cecelia Lesny ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Poland ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Poland

14 Informant Martin H Lesny (Address) 604 S Linwood Ave

15 Filed 5-27-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1 1930 to May 27 1930

that I last saw h[illegible] alive on May 27 1930

and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 27 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) William Ryzewski M. D.

5-27-1930 (Address) 801 S Chester St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL May 30 1930

20 UNDERTAKER M. W. E. Dippel Inc — ADDRESS 37 S Arch St

Louis Frenie 90

E 57501

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57501

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1139 W. Franklin ST. 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Frenie,

(a) RESIDENCE NO. 1139 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE~~ of Caroline S. Frenie.

6 DATE OF BIRTH (month, day, and year) February 14, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Frenie.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lawrence Frenie

(Address) 1139 W. Franklin St

15 Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 26 1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to May 26, 1930, that I last saw him alive on May 26, 1930, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Senile arterio-sclerosis and myocarditis

one yr. 5 mon. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evid.

(Signed) Henry Cohn, M. D.

5-26, 1930 (Address) 1300 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL MAY 28 1930

20 UNDERTAKER Geo M Little

ADDRESS 2700

REMOV...

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57502

E 57502

74-001

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 N. Port ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Elizabeth Sheridan,

(a) RESIDENCE NO. 1623 N. Port ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, ~~or divorced~~
~~HUSBAND~~ of
(or) WIFE of Asbury Sheridan

6 DATE OF BIRTH (month, day, and year) October 8. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Sran,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mevina Hall.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant Mrs Samuel B Springman
(Address) 1623 N Port St

15 Filed MAY 27 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 26 1930

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1930, to May 26, 1930,

that I last saw h... alive on May 25, 1930

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. 65 ds.

CONTRIBUTORY Ephemothorax
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

May 27 1930 (Address) 1832 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL MAY 29 1930

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE

OF DEATH in plain terms, so that it may be properly classified. Exact statements are important. See instructions on back of certificates.

AY 27 1930

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57503

CERTIFICATE OF DEATH.

188-002 E 57503

28-71

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) West Baltimore General (Hospital)

2-FULL NAME John Roland Hoke

(a) RESIDENCE NO. 508 Drury Lane, Ten Hills St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 29, 1922

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	7	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Roland K. Hoke

11 BIRTHPLACE OF FATHER (city or town) Fairchild

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mildred Schuck

13 BIRTHPLACE OF MOTHER (city or town) Sunbury

(State or country) Pennsylvania

14 Informant Mr. Roland K. Hoke

(Address) 508 Drury Lane, Ten Hills

15 Filed ..... 19 .....

WILLISON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated, above.

The CAUSE OF DEATH was as follows: Accident Street Car Fractured Skull

(Duration) ... yrs. ... mos. 2 hours ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.

(Coroner)

May 26 (Address) 3517 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State Life ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudoun Cemetery Date of Burial May 28 1930

20 UNDERTAKER J. D. Cook ADDRESS 1003 West Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 27 1930

Spec.—1-30—M. & T.—250 Blks.

E 57504 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57504

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2829 Elliott ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Eccelia Bowers

(a) RESIDENCE NO. 2829 Elliott ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10th 1901

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER William Bowers

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaretta Lightner

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Margaretta Bowers
(Address) 2829 Elliott St

15 Filed 7 1930 By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25th 30

17 I HEREBY CERTIFY, That I attended deceased from June, 1928, to May 25, 1930, that I last saw her alive on May 25, 1930, and that death occurred, on the date stated above, at 7.50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis.-

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pericarditis.

(duration) yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No -

What test confirmed diagnosis? Urine & Blood.

(Signed) Lewis Hoover, M. D.

19 (Address) Medical Arts Bldg -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL May 25 1930

20 UNDERTAKER Lilly & Zeller Inc

ADDRESS 403 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

42

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57505

CERTIFICATE OF DEATH

100-001

E 57505

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 874 Pierce St. 18-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roland Gamble

(a) RESIDENCE NO. 874 Pierce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Negro	Single

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	1			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Gamble

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Edna Dixon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Charles Gamble
(Address) 874 Pierce St.

15 Filed ..... 19 C. HAMPSON JONES, M.D. Registrar

MAY 27 1930

For

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Primary Broncho-pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fuller, M. D.

5/25, 1930. (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 5-26 1930

20 UNDERTAKER Dent & Gorton

ADDRESS 966 Ca ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57506

CERTIFICATE OF DEATH

7 4 001 E 57506

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 18-76 Ward)

2-FULL NAME James Bennett

(a) RESIDENCE NO. 5 N. Amity St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant James Bennett
(Address) 5 N. Amity St

15 Filed ....., 19.. C. HAMPSON JONES M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene Feldman, M. D.

5/26 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MT Auburn Cem	5-26-30
20 UNDERTAKER David Easton	ADDRESS 916 Pr

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57507

CERTIFICATE OF DEATH.

E 57507

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 510 Stockton St. (WARD) 18-Na

2-FULL NAME Charles White

(a) RESIDENCE NO. 510 Stockton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	married

5a If married, widowed, or divorced HUSBAND of / WIFE of Charlotte White

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Commodore White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Rachel —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Charlotte White

(Address) 575 N Mount St

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 30

17 I HEREBY CERTIFY, That I attended deceased from Feb 27 1930 to May 24 1930

that I last saw him alive on May 24 1930

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Frank Lingenfelter M. D.

5/26, 1930 (Address) 906 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	5-26 1930
20 UNDERTAKER Lewis Easton	ADDRESS 916 Pa Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57508

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57508

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto City Hosp. R-12-45

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Susan Middleton

(a) RESIDENCE No. 1156 N Stricker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 887

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Unknown
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Middleton

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Richardson

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Maryland

14 Informant Hospital Records
(Address) Balto City Hosp.

15 Filed MAY 27 1930, 19 ..... THOMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-23-30

17 I HEREBY CERTIFY, That I attended deceased from 5-13-, 1930, to 5-28-, 1930,

that I last saw her alive on 5-23-, 1930,

and that death occurred, on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid Colon

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of Unknown

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Paul M. Burkett, M. D.

, 19 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 5/27 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pressman St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57509 ✓ E 57509

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 327 N Calhoun ST. 19-16 WARD)

2—FULL NAME Augusta S. Myers

(a) RESIDENCE NO. 327 N Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 12 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Charles Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Augusta Bachar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charles E. Myers

(Address) 327 N Calhoun

15 Filed ..... 19 ..... C. HAMPSON JONES Registrar

MAY 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/25/30

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1928, to May 25, 1930, that I last saw h-e alive on May 23, 1930 and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Abscess (Tuberculosis)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Sputum - Mantoux

(Signed) W. J. Gamm, M. D.

5/26, 1930 (Address) 6 W Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 27 1930
20 UNDERTAKER George J. Smith	ADDRESS 153 Gilmor St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS, please make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 57510

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57510

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1626 Hollins (St.) 19-28 (Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Ecardl

(a) RESIDENCE NO. 1626 Hollins st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced — (or) WIFE of Henry Ecardl

6 DATE OF BIRTH (month, day, and year) May 1, 1845

7 AGE — Years: 85 — Months: ..... — Days: 25 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None do

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Ziegler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louise Ziegler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Adolph Ecardl 1626 Hollins st

15 Filed MAY 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1930

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to May 26th, 1930, that I last saw h[illegible] alive on May 26th, 1930, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Senility

Nephritis

(duration) yrs. 9 mos ..... ds.

CONTRIBUTORY (Secondary) General Breakdown

Bed Sores

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas R Davis M. D.

, 19 (Address) 2108 Brookfield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet

DATE OF BURIAL: May 28 1930

20 UNDERTAKER: F Vernon Kehner

ADDRESS: Hollins 1532

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

57511

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-00 E 57511

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2800 Boston St., 1-1 Ward)

2-FULL NAME John E. Jennings

(a) RESIDENCE NO. 2800 Boston St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colord	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) V.a

PARENTS

10 NAME OF FATHER Chester Jennings

11 BIRTHPLACE OF FATHER (city or town)
(State or country) V.a

12 MAIDEN NAME OF MOTHER Lucy Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) V.a

14 Informant Jordan E. Jennings
(Address) 24a Wilson St

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis

(duration) ... yrs. ... mos. — ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. C. Yates, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

DATE OF BURIAL May 28 1930

20 UNDERTAKER Edward Bryan

ADDRESS 163 Orleans st

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 27 1930

Spec.—1-10-21—M&T—1500 Bks.

E 57512

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57512

CERTIFICATE OF DEATH.

101-001

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 406 Eislen St (St.) 27-30 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Coleman

(a) RESIDENCE NO. 406 Eislen St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wesley Coleman

6 DATE OF BIRTH (month, day, and year) Aug 14-1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	9	10	

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U.S.

PARENTS

10 NAME OF FATHER Thomas Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Malinda Wimbush

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Clara Smith (Address) 406 Eislen St

15 Filed MAY 27 1930, 19 Bur. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1930

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to May 24, 1930, that I last saw h[illegible] alive on May 24, 1930, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 1 mos 21 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) H. A. Smith M. D.

May 26 1930 (Address) 129 N. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn | DATE OF BURIAL May 29 1930

20 UNDERTAKER J L Brown & Son | ADDRESS 108 W Monty

Spec.—1-30—M. & T.—250 Blks

E 57513 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 57513

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. 17-49 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert F. Stevenson

(a) RESIDENCE NO. Washington, Pa. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Mrs. Robert Stevenson

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

086

9 BIRTHPLACE (city or town) Ligonier, Pa.
(State or country)

PARENTS

10 NAME OF FATHER Ross Stevenson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Martha Harkins

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Penn.

14 Informant Mrs. Robt. Stevenson
(Address) Washington Pa

15 Filed MAY 27 1930, 19 ... By ..... Registrar

C. HARRISON BURNS, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 30

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1930, to May 26, 1930, that I last saw him alive on May 26, 1930 and that death occurred, on the date stated above, at 9:40 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? Yes Date of May 20 1930

Was there an autopsy? Yes. (Partial)

What test confirmed diagnosis? Operation findings

(Signed) Samuel McLanahan, M. D.

May 26 1930 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington Pa

DATE OF BURIAL May 28 1930

20 UNDERTAKER John O'Mitchell & Son

ADDRESS 1900 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57514

CERTIFICATE OF DEATH.

16 1-001 E 57514

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 710 Glenwood Ave ST. 27-48 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Robert Firewood

(a) RESIDENCE No. 710 Glenwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) May 25 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			one	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 710 Glenwood Ave Balto Md

PARENTS

10 NAME OF FATHER Chas. Leo Firewood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co

12 MAIDEN NAME OF MOTHER Ethel Alice Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant (Address) Chas Leo Firewood 710 Glenwood Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1930

17 I HEREBY CERTIFY, That I attended deceased from May-25 1930 to May 26 1930, that I last saw h-- alive on May 26 1930, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH was as follows:*

Premature Birth

(duration) yrs. mos one ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H C Hess, M. D.

5-26 1930 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	May 27 1930
UNDERTAKER	ADDRESS
John O Mitchell & Son	1900 Eastern Ave

MAY 27 1930

Spec.—2-29-28—L. F. S.—509 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57515 — REGISTERED NO. E 57515

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 13-59 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Earl Thomas

(a) RESIDENCE NO. 2416 Woodbrook Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER William Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Lilly Dobson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant William Thomas
(Address) 2416 Woodbrook Ave

15 Filed MAY 27 1930, 19 H. HANSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1930, to May 26, 1930, that I last saw him alive on May 26, 1930, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningetis
(Tuberculous)
(duration) yrs. 16 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Lumbar puncture and autopsy

(Signed) Myron G. Zell, M. D.

5/27, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL May 27, 1930

20 UNDERTAKER Thomas F. Wright — ADDRESS 740 N Carrollton Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57516 ✓ E 57516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST., 5-6 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L. O'Bannon

(a) RESIDENCE No. 1210 Peterson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? — yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-18-1857

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
73	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Labor

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer —

9 BIRTHPLACE (city or town) Pleasureville
(State or country) Kentucky

PARENTS

10 NAME OF FATHER Wm O'Bannon

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Ky.

12 MAIDEN NAME OF MOTHER Mary Bohne

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Ky.

14 Informant Records
(Address) BALTIMORE CITY HOSPITALS

Filed MAY 27 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-25-30

17 I HEREBY CERTIFY, That I attended deceased from 2-2, 1930, to 5-25, 1930,

that I last saw him alive on 5-25, 1930,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) 1½ yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ½ yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marcus H. McCann, M. D.

5-25, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 5-27 1930

20 UNDERTAKER Byrom & Wright

ADDRESS 1218 N. Eden & Elderry St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 57517

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57517

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2600 Strathmore Ave. 27-55 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J. Stubbs

(a) RESIDENCE. No. 2600 Strathmore Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Albert M. Stubbs

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Worcester Co. (State or country) Virginia

PARENTS

10 NAME OF FATHER Clayton Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Victoria Lunsyelin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) A. Norton Stubbs 2600 Strathmore Ave

15 Filed MAY 27 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/26 19 30

17

I HEREBY CERTIFY, That I attended deceased from Jan., 1930, to 5/26, 1930, that I last saw h— alive on 5/26, 1930, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ryland W. Dolby, M. D.

19 (Address) 5103 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	May 28 1930
20 UNDERTAKER	ADDRESS
Jacob Byer	1600 N. Wolfe st

N. B.—WRITE PLAINLY, WITH PEN AND INK—THIS IS A LEGAL DOCUMENT. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57518

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57518

161-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 14-51

CITY OF BALTIMORE: (No. 2234 Madison Ave. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Ford Paul Eugene Ford

(a) RESIDENCE NO. 2234 Madison Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-21-30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
6 days.	0	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER James Ford.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Edna Buchanan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant mother.
(Address)

15 Filed MAY 27 1930 19 C. HAMPSON JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-27-30

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1930, to May 27, 1930, that I last saw him alive on May 26th, 1930 and that death occurred, on the date stated above, at 1:00 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis

(Signed) M. Alexander Lowey, M. D.

, 19 (Address) 15-16 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 5/27/1930

20 UNDERTAKER Geo. H. Holland

ADDRESS 1631 Druid Hill Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57519

E 57519

CERTIFICATE OF DEATH

44

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1355 Homestead ST., 9-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lula S. Dietrich

(a) RESIDENCE NO. 1355 Homestead ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 2 mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced

(or) WIFE of J Harmon Dietrich

6 DATE OF BIRTH (month, day, and year) Mar 21st 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Otto H Werner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Hoffert

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Germany

14 Informant Wilhelmina M. Dietrich

(Address) 1355 Homestead st

15 Filed MAY 27 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26/1930

17

I HEREBY CERTIFY, That I attended deceased from 5/1, 1927, to 5/26, 1930

that I last saw h er alive on 5/25, 1930

and that death occurred, on the date stated above, at 10 25 a m. Standard time

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver, Spleen, Pancreas - Visceral abdominal involvement.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H W Hoffert, M. D.

5/27, 1930 (Address) 2020 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	May 28th 1930
20 UNDERTAKER	ADDRESS
George Schilling & Sons	422 E Monument St

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 57520 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 57520

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH Hospital for Women of Md REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Pierce Bruns

(a) RESIDENCE NO. 132 W. Lanvale ST., Baltimore WARD Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or WIFE of) the late John Nelson Bruns of New Orleans

6 DATE OF BIRTH (month, day, and year) Oct 2, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): New Orleans Louis.

PARENTS

10 NAME OF FATHER Levi Pierce

11 BIRTHPLACE OF FATHER (city or town) (State or country): Salem, Mass

12 MAIDEN NAME OF MOTHER ~~Mary~~ Clarinta Hyde

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Philadelphia

14 Informant: Mrs Pierce Bruns

(Address) 132 W. Lanvale St.

15 Filed MAY 27 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1930, to May 27, 1930, that I last saw h.CA alive on May 27, 1930, and that death occurred, on the date stated above, at 5:02 A m.

The CAUSE OF DEATH* was as follows:

Uremia following chronic nephritis & hernia.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ur not rec'd for 3 days

(Signed) J. G. Lynch Jr., M. D.

, 19 (Address) Womens Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 5-28-1930

20 UNDERTAKER: Hamilton Jenkins-Ives Co.

ADDRESS: Orchard & McCulloh

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57521 ✓ E 57521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

86-002

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No.) Caroline & Oliver ST. 26 WARD

REGISTERED NO. 26-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Olympia Winterling

(a) RESIDENCE NO. 3724 Foster Ave ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 14 1928

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
1	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Frederick G. Winterling

11 BIRTHPLACE OF FATHER (city or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Madeline Hamel

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md

(State or country)

14 Informant Frederick G. Winterling

(Address) 3724 Foster Ave

15 Filed MAY 27 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24th/30

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930 to May 27, 1930, that I last saw h[illegible] alive on May 24, 1930 and that death occurred, on the date stated above, at 1.55 A.m.

The CAUSE OF DEATH* was as follows:

Mastoiditis

Meningitis (un known organism)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Respiratory Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/15/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) V. Messina, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL May 27th 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 408 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57522

E 57522 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 49

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 7-9 (WARD)

2-FULL NAME Gotlieb Sommer

(a) RESIDENCE NO. Turner Station Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred XX yrs. mos. da. / How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Anna Sommers

6 DATE OF BIRTH (month, day, and year) Mar. 23-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Piano Tuner

(b) General nature of industry, business, or establishment in which employed (or employer) o/o

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ger.

PARENTS

10 NAME OF FATHER Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Beatrice Waler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed 19 C. HAMPSON JONES, M. Registrar

MAY 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25-1930

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1930 to May 25, 1930, that I last saw him alive on May 25, 1930, and that death occurred, on the date stated above, at 1.50 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate gland.

(duration) 3 yrs. mos da.

CONTRIBUTORY (Secondary) Pulmonary embolism

(duration) yrs. mos. 4 days.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? yes Date of April 20, 1930

Was there an autopsy? no

What test confirmed diagnosis? biopsy

(Signed) Edward C. Jones M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL May 28 1930

UNDERTAKER George L. Schwab — ADDRESS 201 Fulk Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

(William H. Angerman)

HEALTH DEPARTMENT CITY OF BALTIMORE

E 57523

CERTIFICATE OF DEATH

90

E 57523

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St., 9-46 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME W. H. ~~Angerman~~ Angerman

(a) RESIDENCE NO. ~~2320~~ 2820 Kennedy Av St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed or Divorced, (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 7. 1843

7 AGE: Years 87 | Months 3 | Days 7 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): Retired
(c) Name of employer

9 BIRTHPLACE (city or town): N. C.
(State or country)

PARENTS

10 NAME OF FATHER: W. Angerman

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER: Mary Ann

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: William J. Angerman
(Address) 2820 Kennedy Ave

15 Filed May 28 1930 C. HAMPSON JONES, Registrar
By [illegible]

5/27/1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv dis. heart
endocard
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. T. Talley, M. D.

May 28. 1930 (Address) 1659 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 28 1930
20 UNDERTAKER	ADDRESS
J. W. Teufel & Son	801 N. Fayette

Spec.—2-29-28—L. F. S.—500 Blks. Vernon 2301 - 9.30

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57524 X 84 E 57524

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 11-15

CITY OF BALTIMORE: (No. 1039 N. Calvert ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. H. H. MacNeish

(a) RESIDENCE NO. 185 Lakeview Ave, Scarsdale N.Y. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of H. H. MacNeish

6 DATE OF BIRTH (month, day, and year) Nov 20 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	41	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bayonne N.J.

PARENTS

10 NAME OF FATHER Elmer E. Stockton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Patterson N.J.

12 MAIDEN NAME OF MOTHER Ida M Stone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frankford N.Y.

14 Informant Edwin L Bennett
(Address) Scarsdale N.Y.

15 Filed C. HAMPSON JONES, M. D. Registrar
Y 2 71930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to May 27, 1930, that I last saw her alive on May 27, 1930 and that death occurred, on the date stated above, at 9.45 A m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? Scarsdale, N.Y.

Did an operation precede death? No Date of —

Was there an autopsy? Yes - Brain tumor

What test confirmed diagnosis? Autopsy

(Signed) John A. Treadler, M. D.

May 27 1930 (Address) 1035 N. Calvert St.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Scarsdale N.Y.	May 27 1930
20 UNDERTAKER	ADDRESS
Henry Hankins & Son	Oakland & Caldwell Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57525 X 171 E 57525

CERTIFICATE OF DEATH

1—PLACE OF DEATH The Church Home + Infirmary 6-9 REGISTERED NO.

CITY OF BALTIMORE: (No. Fairmount + Broadway ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Robert Miller

(a) RESIDENCE NO. Rodgers Forge - Towson ST. Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 23 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER R J. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Maria Kelsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Doris Mallinckrodt

(Address) Baltimore Md

15 Filed C. HAMPSON JONES, M. D. Registrar

By A.S.

MY 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1930

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1930, to May 26, 1930, that I last saw him alive on May 26, 1930, and that death occurred, on the date stated above, at 8.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bromide Poisoning

7 years

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Chemistry

(Signed) Vernon H Norwood, M. D.

May 22, 1930 (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL May 28 1930

20 UNDERTAKER Henry Heuken Sons Co

ADDRESS Crescent Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

(John W. Scheler)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57526

CERTIFICATE OF DEATH

153

E 57526

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Mercy Hospital 8-17 St. (Ward)

2-FULL NAME John Scheler

(a) RESIDENCE NO. 1511 Rutland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Anna E Scheler

6 DATE OF BIRTH (month, day, and year) July 4 1859

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	70	10	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Christopher Scheler

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Huber

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Anna E. Scheler
(Address) 1511 Rutland

15 Filed MAY 27 1930 C. HAMPSON JONES, M. D. Registrar
per Reed

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cellulitis Leg.

(Caused by) accidental Cut on Leg

(duration) 3 mos. about

CONTRIBUTORY (Secondary) Anemia Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. T. Riley, M. D.

May 27 1930 (Address) 1659 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: May 29 1930

20 UNDERTAKER: George E. Schilling

ADDRESS: 1306 N. Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57527 — 31 — E 57527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2309 Annapolis Road St. 25-3 WARD)

REGISTERED NO. .....

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry March

(a) RESIDENCE NO. 2309 Annapolis Road ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of or ~~WIFE of~~ Clara March

6 DATE OF BIRTH (month, day, and year) 1/22/98

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
32	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Move Man

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER William March

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Emma K Schmidt

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Clara March
(Address) 2819 Harlem Ave

15 Filed ..... 19 ..... Registrar

C. HAMPSON GORE, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27-30

17 I HEREBY CERTIFY, That I attended deceased from June, 19 29 to May 26, 19 30, that I last saw h[illegible] alive on May 26, 19 30, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Harry Glassman M. D.

May 27 1930 (Address) 268 S Mersken Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 5/29/19 30

20 UNDERTAKER Wm Cook 1217 E Fayette St

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—25¢ Bks

Dr Miller 1500 N. Broadway

E 57528 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57528

CERTIFICATE OF DEATH.

100

8-16

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1918 N. Patterson Pk Ave ST., WARD)

2-FULL NAME Robert T. Andrews

(a) RESIDENCE NO. 1918 N. Patterson Pk Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5th 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Edwin A. Andrews

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Ey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Edwin A Andrews
(Address) 1918 N. Patterson Pk Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.
By ..... Registrar

Y 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26th 1930 4 P.M.

17 I HEREBY CERTIFY, That I attended deceased from 5/24, 1930, to 5/26, 1930, that I last saw him alive on 5/26, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Howard Carter, M. D.

5/26, 1930 (Address) 1500 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetary — DATE OF BURIAL 5/28/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57529

CERTIFICATE OF DEATH

86-001 E 57529

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hosp (ST.) (WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alberta Dellinger

(a) RESIDENCE NO. 2633 Dulany St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert C Dellinger

6 DATE OF BIRTH (month, day, and year) Dec 8 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Vogel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alverda B Hummell

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balt Md

14 Informant Albert C Dellinger

(Address) 2636 Dulany St

15 Filed ....., 19.... C. HAMPSON GIBBS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1930

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to May 26, 1930, that I last saw h e alive on May 26, 1930 and that death occurred, on the date stated above, at 6:40 P m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Meningitis (Non Epidemic)

(duration) ....yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Otitis Media

(duration) ....yrs. mos. 27 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? Partial

What test confirmed diagnosis? Laboratory Reports

(Signed) Arthur Rathmell, M. D.

5/26, 1930 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetary — DATE OF BURIAL 5/29/1930

20 UNDERTAKER Wm Cook 1219 St Paul St — ADDRESS

MAY 7 1930

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57530

CERTIFICATE OF DEATH

H E 57530

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 125 N. Curley St. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Wasel (Wasielewska)

(a) RESIDENCE NO. 125 N Curley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anthony

6 DATE OF BIRTH (month, day, and year): ? 1875

7 AGE: Years 52 Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Poland.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Poland.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Anthony Wasel

(Address) 125 N Curley St

15 Filed MAY 27 1930

C. HAMPSON JONES, M. D. Registrar

No. 4005

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1- 1930 to May 26 1930

that I last saw h alive on May 25 1930

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Right Breast

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? Yes Date of Unknown.

Was there an autopsy? —

What test confirmed diagnosis? Surg History

(Signed) C. E. Wades, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross May 28 1930

Date of Burial

20 UNDERTAKER: J. H. Bozenski

ADDRESS: Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57531

CERTIFICATE OF DEATH

135 E 57531

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 16-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augustus Conklin

(a) RESIDENCE NO. 907 N.Stricker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Conklin

6 DATE OF BIRTH (month, day, and year) Aug 9/1853

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	76	9	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Messenger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto. Trust Co.

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Conklin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Bright

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Emma Conklin
(Address) 907 N. Stricker St

15 Filed MAY 27 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to yes death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Odema-Hydrothorax

Benign Prostatic Hypertrophy-

Retension.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? Yes at Hopkins Hospital

What test confirmed diagnosis?

(Signed) J. H. Hall M. D.

5/28/30 (Address) 500 E.North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 5/29/1930

20 UNDERTAKER Jas. Geo. H. Holland — ADDRESS 1631 Druid Hill Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57532 — CERTIFICATE OF DEATH. — E 57532

X101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. St. H-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ann Clark

(a) RESIDENCE NO. Elkton, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elkton Maryland

PARENTS

10 NAME OF FATHER William Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 Filed MAY 27 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/27 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-11, 1930, to 5-27, 1930,

that I last saw her alive on 5-27, 1930

and that death occurred, on the date stated above, at 7.30 p m.

The CAUSE OF DEATH* was as follows:

Empyema of Pleural Cavity — Rt.

Pericarditis

(duration) yrs. mos. 21? ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 5/27/30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M. C. Porter Fiscel, M. D.

5/27. 1930 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkton Cemetery	May 30 1930.
20 UNDERTAKER	ADDRESS
H. W. Peppin	Elkton Md.

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57533

CERTIFICATE OF DEATH

18 E 57533

1-PLACE OF DEATH (Coroner's Office) 11-24

REGISTERED NO.

City of Baltimore: (No. [redacted] St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Goddard Baltus

(a) RESIDENCE NO. 1238 Argyle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dorothy

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years 44 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Coroner
(b) General nature of industry, business, or establishment in which employed (or employer): 040
(c) Name of employer

9 BIRTHPLACE (city or town): Va
(State or country)

PARENTS

10 NAME OF FATHER: Samuel Baltus

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: Jennie Saunders

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country)

14 Informant: Dorothy Baltus
(Address): 1238 Argyle St.

15 [illegible] (Registrar)

MAY 27 1930

Fee 10 cts

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 24th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

Sudden

Fell down stairs

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) H. Falk, M. D.

May 24 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: 5/28/1930

20 UNDERTAKER: Daniel Easton — ADDRESS 917 Penna. Ave

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 57534 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57534

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1845 W Lombard St. ST., 9-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Engelbach

(a) RESIDENCE NO. 1845 W Lombard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Louis Engelbach

6 DATE OF BIRTH (month, day, and year) June 7th. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry W. Oswald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Glenn E. Rice

(Address) 1845 W Lombard St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1930.

17

I HEREBY CERTIFY, That I attended deceased from April 13, 1930, to May 25, 1930, that I last saw h[illegible] alive on May 25, 1930, and that death occurred, on the date stated above, at 12.50 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of intestine, with metastasis to liver

dont Know.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) cardiac failure

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual tests.

(Signed) George A Kupp, M. D.

, 19 (Address) 3030 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 5/28/30

20 UNDERTAKER Harry A Witzke — ADDRESS 4[illegible] Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 2 1930 C. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Blks.

E 57535

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57535

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST., 8-12 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter J. Dignan

(a) RESIDENCE NO. 1329 N. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 15 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer) 084

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, (State or country) Md.

PARENTS

10 NAME OF FATHER John Dignan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Grogan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Julia A. Dignan

(Address) 1324 Chester St.

15 Filed MAY 27 1930 19 ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-26-30

17 I HEREBY CERTIFY, That I attended deceased from 5-17, 1930, to 5-26-, 1930, that I last saw h~~e~~ alive on 5-26, 1930 and that death occurred, on the date stated above, at 7 55 m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos 23 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & X Ray

(Signed) Wm. Hendrix M. D.

5/26/1930 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 5/30 1930

20 UNDERTAKER Harry A. Witzke, 4101

ADDRESS Edmondson Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Blks.

E 57536 HEALTH DEPARTMENT—CITY OF BALTIMORE 54 ✓ E 57536

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO. .....

CITY OF BALTIMORE, NO. 7 Baltimore ST., 45-68 WARD — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Rother

(a) RESIDENCE NO. 1641 N. Smallwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 14 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Freeman

6 DATE OF BIRTH (month, day, and year) abt. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
abt. 64	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 60

(b) General nature of industry, business, or establishment in which employed (or employer) Painter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Chris Rother

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records in Bal. City Hosp. (Address)

15 Filed MAY 28 1930 C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-26-30

17 I HEREBY CERTIFY, That I attended deceased from 5-17-, 1930, to 5-26, 1930, that I last saw him alive on 5-26, 1930, and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:
Senile & arteriosclerotic Heart Disease

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pellagra

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Mary F. Thrush, M. D.

5/27 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U. S. Nat. Cem. Baltimore — DATE OF BURIAL 5/29/30

20 UNDERTAKER Mary T. Duffy Sons — ADDRESS 1735 Hanford Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57537 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57537

31

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO. 9-44

CITY OF BALTIMORE: (No. 1701- Gorsuch ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph A. Kotz

(a) RESIDENCE NO. 1701- Gorsuch ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/15/1904

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
26	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Johnstown Pa

PARENTS

10 NAME OF FATHER August G. Kotz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Boyles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. Caroline Kotz

(Address) 1701- Gorsuch Ave.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1930

17

I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1928, to May 28, 1930

that I last saw h. alive on May 27, 1930

and that death occurred, on the date stated above, at 2 30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence.

(Signed) Geo. B. Dysert, M. D.

, 19 (Address) 2802 Harford ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem. DATE OF BURIAL 5/30/1930

20 UNDERTAKER Mary T. Butler ADDRESS 1735 Harford

IF DEATH IS PRINTED, so that it may be properly classified. LAST STATEMENT OF OCCUPATION IS VERY important. See instructions on back of certificates.

MAY 29 1930 C. H. JONES, M.D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57538

CERTIFICATE OF DEATH.

31

E 57538

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1229 Clondale Rd St. 13-59 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Boyce

(a) RESIDENCE NO. 1229 Clondale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Randolph Boyce

6 DATE OF BIRTH (month, day, and year) Unknown 1879

7 AGE Years 51 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Hebron

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Matilda Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Agnes Hebron

(Address) 1229 Clondale Rd.

Filed MAY 28 1930 . 19 C. HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 . 1929 . to May 27 . 1930 .

that I last saw her alive on May 25 . 1930 .

and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. mos ds.

CONTRIBUTORY/ (Secondary) Tuberculosis of Lungs

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum + urine test

(Signed) Wm Fry, M. D.

5/27 . 1930 (Address) 1928 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL May 30 1930

UNDERTAKER James E. Wyatt

ADDRESS 700 N. Eden St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57539 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓

91-002 E 57539

CERTIFICATE OF DEATH

1—PLACE OF DEATH U. S. Marine Hospital Baltimore Maryland

REGISTERED NO.

CITY OF BALTIMORE: (No. 12-51 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William James Morris

(a) RESIDENCE NO. Ditchley, Virginia ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Morris

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deck Hand

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS William H. Killman

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER Warner Morris

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER Julia Betts

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant U. S. Marine Hospital, Records. (Address) Baltimore, Maryland.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to May 27, 1930, that I last saw him alive on May 27, 1930 and that death occurred, on the date stated above, at 8:05 a.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis, general

undetermined (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia, acute, cause- hypertrophy of prostate (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory & Clinical

(Signed) E. M. Townsend, M. D.

, 19 (Address) U.S. Marine Hospital, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Northumberland Ditchley Wharf Co Va

DATE OF BURIAL May 28 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pressman St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 28 1930 HAMPSON JONES, M

Spec. 1-30—M. & T.—250 Bks.

E 57540 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 57540

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST. 12-14 (WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Tabbs

(a) RESIDENCE NO. 314 Worsley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Walter

6 DATE OF BIRTH (month, day, and year) June 10, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69	70	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Fairfax

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Harriet Parker

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed MAY 28 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-24-30

17 I HEREBY CERTIFY, That I attended deceased from 5-21-30, 19, to 5-24-30, 19,

that I last saw her alive on 5-24-30, 19,

and that death occurred, on the date stated above, at 4.55 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Acute
Coronaries

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; Hypertension

(duration) yrs. mos. over 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical; Autopsy

(Signed) Marvin M. McLean, M. D.

5-26, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL May 28, 1930

20 UNDERTAKER Wm. R. Elliott — ADDRESS 1775 Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

E 57541

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 E 57541

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 100 W. Baltimore St., 6-9 Ward)

2-FULL NAME George B. Garison

(a) RESIDENCE NO. 1604 E. Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Garison

6 DATE OF BIRTH (month, day, and year) October 3. 1888

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41	7.	23.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pensioned Soldier
(b) General nature of industry, business, or establishment in which employed (or employer) No
(c) Name of employer

9 BIRTHPLACE (city or town) Tenn.
(State or country)

PARENTS

10 NAME OF FATHER George D Garison

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Tenn.

12 MAIDEN NAME OF MOTHER Do not know. May 27

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know

14 Informant Julia Garison (wife)
(Address) 1604 E Baltimore St

15 Filed ..... 19.. HAMPSON JONES M D Registrar

MAY 28 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
Obstruction of Coronary Arteries

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? By Inquiry

(Signed) Otto M Reinhardt M. D.

May 27 1930 (Address) 1017 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood — DATE OF BURIAL May 29 1930

20 UNDERTAKER Louis Heiman — ADDRESS 32 S Broadway

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 57542 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 57542

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St. 15-58 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sigild-Socket Shvekrt

(a) RESIDENCE NO. 3425 Reisterstown Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Annie Shvekrt

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Lewis Shvekrt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1739 E Balt St

15 Filed May 28 19 30 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/27/30

17 I HEREBY CERTIFY, That I attended deceased from 5/24, 1930, to 5/27, 1930, that I last saw him alive on 5/27, 1930, and that death occurred, on the date stated above, at 11:55 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 1 yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. A. Silver, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Memory Gdns

DATE OF BURIAL May 28 1930

20 UNDERTAKER Jack Lewis, 1739 E Balto, Md

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 28 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57543 ✓ E 57543

46

CERTIFICATE OF DEATH

E 57543

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 705 Lennox St. ST. 13-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella B. Sommerlock,

(a) RESIDENCE NO. 705 Lennox St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) March 20, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John F. Sommerlock,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Anne Wilkins,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs F. Seybold

(Address) 705 Lennox St

15 Filed MAY 28 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1930, to May 28, 1930, that I last saw her alive on May 27, 1930 and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 3 yrs. mos. da.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Edwin K. Ballard, M. D.

5-28-1930 (Address) 162 W Mt Royal Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL MAY 31 1930

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57544

CERTIFICATE OF DEATH

90 ✓ E 57544

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 6000 Belair Road St., 27-42 Ward)

2-FULL NAME CALVIN E. BIEN

(a) RESIDENCE NO. 6000 Belair Road St., Ward

(Usual place of abode) life

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 24th, 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ... min.
	35	6	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Bien

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E. Thomas

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mary E. Bien
(Address) 6000 Belair Road

15 Filed ..., 19... C. HAMSON JONES M.D. Registrar

MAR 2 5 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26th, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis (Valv Insuff)

(duration) 22 yrs. mos. ds.

CONTRIBUTORY (Secondary) Typhoid Fever at 13 yrs of age (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Bacon, M. D.

5/25/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	May 29 1930

20 UNDERTAKER Frederick Lassahn ADDRESS Fullerton

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 57545 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57545

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1817 Wilkens Ave ST. 19-28 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Gimbel

(a) RESIDENCE NO. 1817 Wilkens Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Conrad Gimbel

6 DATE OF BIRTH (month, day, and year) Feb 14, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John H. Gimbel

(Address) 1817 Wilkens Ave

Filed MAY 28 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26th, 30.

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1930, to May 26, 1930, that I last saw her alive on May 26, 1930, and that death occurred, on the date stated above, at 1.30P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R Gustav Dick M. D.

5/28 1930 (Address) 1433 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: May 29th 30

UNDERTAKER: F. B. Wippert-1850 W. Baltimore St.

ADDRESS

CAUSE OF DEATH is very important. See instructions on back of certificates. Exact statement of OCCUPATION is necessary. If in doubt what to write, say so, that it may be properly classified.

Spec.—1-12-23—M&T—500 Blks.

E 57546 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57546

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25-19 Madison St. 13-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Smith

(a) RESIDENCE NO. 25-19 Madison Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER Alfred Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Louise Bird

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Ida Hearns
(Address) 25 19 Madison Ave

15 Filed ..., 19... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/29 1930

17 I HEREBY CERTIFY, That I attended deceased from 5/23, 1930, to 5/29, 19..., that I last saw him alive on 5/27, 1930 and that death occurred, on the date stated above, at 5-30 P M.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(duration) ? yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burt Rhett, M. D.

5/29 1930 (Address) 25 19 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL May 29 19 30

20 UNDERTAKER Turner & Brock

ADDRESS 1463 Mary

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57547

CERTIFICATE OF DEATH

90 E 57547

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2107 Gough ST., 12 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Kollner

(a) RESIDENCE NO. 2107 Gough ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, ~~or Divorced~~ (write the word)
Female	white	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife Henry Kollner

6 DATE OF BIRTH (month, day, and year) May 22 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Henrietta Fost

(Address) 2107 Gough st. Baltimore

15 Filed MAR 28 1930 C. HARPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27-1930

17

I HEREBY CERTIFY, That I attended deceased from May 19 24, to May 27 19 30.

that I last saw h 24 alive on May 27 19 30

and that death occurred, on the date stated above, at 10 50 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart disease

Chr. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocardial dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Grace F. Taylor, M. D.

5/29, 19 30 (Address) 2007 E. Baltimore

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem't.	May 30 1930
20 UNDERTAKER	ADDRESS
Lilly & Zeiler Inc.	4033 Wolfe st

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57548 — 90 ✓ — E 57548

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Levindale — REGISTERED NO. 27-54

CITY OF BALTIMORE: (No. ..... S. ..... WARD) ..... (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Sherman.

(a) RESIDENCE No. Belvedere & Greenspring Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Isidore

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE: Years 85 — Months — — Days — — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Sherman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Hebrew Aged Home Levindale

15 Filed MAY 28 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1930

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1930, to May 27, 1930, that I last saw h. alive on May 26, 1930, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular heart disease.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) M. Edmund Levin, M. D.

5/27 1930 (Address) Levindale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Hebrew Herring Run — DATE OF BURIAL 5/28 1930

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 57549

HEALTH DEPARTMENT—CITY OF BALTIMORE

VE 57549

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 N. Montford Ave. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Schleigh

(a) RESIDENCE NO. No. 1208 N. Montford Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) February-1-1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	4 3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Bussiness

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER August. A. Schleigh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Minnie. A. Krausser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Blato. Md.

14 Informant Mr. August. A. Schleigh

(Address) No. 1208 N. Montford Ave.

15 Filed MAY 28 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/27/30

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1930, to May 27, 1930, that I last saw him alive on May 27, 1930, and that death occurred, on the date stated above, at 6:50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) J. Z. Kennedy M. D.

May 29 19 (Address) 1301 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL May 31st 1930

UNDERTAKER Sidney Hoell Sons, Inc. ADDRESS 130 E Eager St

CAUSE OF DEATH and years, months, and days must be properly classified. EXACT SPELLING OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57550

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57550

CERTIFICATE OF DEATH.

REGISTERED NO. 31 ✓ E 57550

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B. 59)

CITY OF BALTIMORE: (No. 13 S. WARD)

2-FULL NAME Thomas Hicks

(a) RESIDENCE NO. 2404 Woodbrook ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 069

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Thomas J. Hicks

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Winnie Moss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records (Address)

Filed 5-28 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 27, 1930, that I last saw him alive on May 27, 1930, and that death occurred, on the date stated above, at 3.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

5-27 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Weldon N. Carolina — DATE OF BURIAL May 28 1930

20 UNDERTAKER Josiah Syfer — ADDRESS 600 W. North Ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57551

E 57551

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 Pierce St. 17-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Holbrook

(a) RESIDENCE NO. 722 Pierce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Blk

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac Holbrook

6 DATE OF BIRTH (month, day, and year): Nov – 1873

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Household work

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Norah Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Natus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harrisburg Va

14 Informant: Ida Martin (Address) 722 Pierce

15 Filed MAY 28 1930 19 C. HUNTER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 1930 to May 24 1930, that I last saw her alive on May 24 1930, and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Diabetis Mellitus

(duration) yrs. 3 mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) Gustav Eisbman, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: May 28 1930

20 UNDERTAKER: Samuel Walmsley

ADDRESS: 575 W Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57552 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57552

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 Dris ave ST., 26-39 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Steinmetz

(a) RESIDENCE NO. 1201 Dris ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Steinmetz

6 DATE OF BIRTH (month, day, and year) July 25 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John B Engel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Sophia Diehl

(Address) 3237 Edmondson Ave

15 Filed MAY 28 1930 Registrar C. HAMPSON JONES M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1930

17 I HEREBY CERTIFY, That I attended deceased from May 22 1930, to May 27 1930, that I last saw h[illegible] alive on May 27th 1930, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Coronary Coronary Thrombosis

Contributory Day Dysentery

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Glover M. D.

May 29 1930 (Address) 1400 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 29 1930

20 UNDERTAKER John Ulrich — ADDRESS 2008 Orleans St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 57553

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57553

CERTIFICATE OF DEATH

185

1-PLACE OF DEATH

City of Baltimore: (No. Providence Hosp. St. 16-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip Brown

(a) RESIDENCE NO. 223 N. Schroeder Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3rd 1930

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		1	23 25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Jacob Meggs

11 BIRTHPLACE OF FATHER (city or town) F. C.
(State or country)

12 MAIDEN NAME OF MOTHER Dorothy Brown

13 BIRTHPLACE OF MOTHER (city or town) Edenton N. C.
(State or country) Md

14 Informant Dorothy Brown
(Address) 223 N. Schroeder

15 Filed ..... 19 ..... C. HAMPSON JONES, Registrar

MAY 28 1930

Ref

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Serondary) Fell out of bed

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation prerede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Regular

(Signed) [illegible], M. D.

(Address) May 29 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Ct	May 28 1930
20 UNDERTAKER	ADDRESS
S. H. Brown & Son	108 W. Mulberry

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 57554 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57554

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 539 Barre ST., 22-30 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Johnson

(a) RESIDENCE NO. 539 Barre ST., 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22, 1911

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
19		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimd.
(State or country)

PARENTS

10 NAME OF FATHER David Johnson

11 BIRTHPLACE OF FATHER (city or town) Eastern
(State or country) Shore Md.

12 MAIDEN NAME OF MOTHER Sarah Topp

13 BIRTHPLACE OF MOTHER (city or town) Fairfax
(State or country) Vide Va.

14 Informant Sarah Johnson
(Address) 539 Barre St

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/27/1930

17 I HEREBY CERTIFY, That I attended deceased from 4/12/, 1930, to 5/27/, 1930

that I last saw h[illegible] alive on 5/27/, 1930

and that death occurred, on the date stated above, at 1.50 m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation
Pulmonary Edema

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & History

(Signed) Wm. Bishop, M. D.

, 19 (Address) 709 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion

DATE OF BURIAL May 29 1930

20 UNDERTAKER J. R. Bruno's Son

ADDRESS York, Maple

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 57555 HEALTH DEPARTMENT—CITY OF BALTIMORE 57555 1930 1922

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST. 25-72 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Herr.

(a) RESIDENCE NO. 1920 Mansel St. City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo Herr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Helen Lang

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Geo Herr 1920 Mansel St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MAY 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-27 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-26 , 1930 , to 5-27 , 1930 ,

that I last saw h[illegible] alive on 5-27 , 1930 ,

and that death occurred, on the date stated above, at 12 00 8 m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem DATE OF BURIAL 5/30 1930

20 UNDERTAKER: Edw Loveren ADDRESS 400 W Lexington St

BIRTHS should be written legibly, with ink. Note should be taken that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Henry Weldrogel Sr ✓

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 57556 E 57556

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH St Agnes Hospital 25-12 REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Henry Weldrogel

(a) RESIDENCE NO. Woodlawn Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 12 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Decorator
(b) General nature of industry, business, or establishment in which employed (or employer) Interior
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Weldrogel
(Address) Woodlawn Md.

15 Filed MAY 28 1930, 19 Registrar G. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-16, 190 . to 5-28. 1930,
that I last saw h alive on 5-28, 1930,
and that death occurred, on the date stated above, at 7.55 a m. Standard time.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy & Acute retention
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Robert Dewar, M. D.

19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem.

DATE OF BURIAL May 30 1930

20 UNDERTAKER Easton Sons

ADDRESS Elkton Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57557 ✓ 1924-D E 57557

E 57557

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Union Hospital

CITY OF BALTIMORE: (NO. Lombard & Green St., 14-20 WARD)

2-FULL NAME Daniel Hicks

(a) RESIDENCE NO. Old Hanford Rd ST., Towson WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None.

6 DATE OF BIRTH (month, day, and year) May 1 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	—	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Harvey Hicks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lottie Bell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md.

14 Informant E. E. Bruce (Address) Towson

15 Filed ..... 19 ..... C. HANSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1929

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1929, to May 28, 1929, that I last saw him alive on May 28, 1929, and that death occurred, on the date stated above, at 7:25 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac disease

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. B. Johnson, M. D.

May 1930 (Address) Union Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. Towson. DATE OF BURIAL May 29 1930

20 UNDERTAKER E. Lee Bruce Towson ADDRESS Towson Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

A 29 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57558 — 24 — E 57558

E 57558

REGISTERED NO. ____

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Provident Hospital ST. 4-25 WARD)

2—FULL NAME Pauline White

(a) RESIDENCE NO. 132 Pearl Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 21 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	—	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lincolnia Heights Maryland

PARENTS

10 NAME OF FATHER John White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore Va.

12 MAIDEN NAME OF MOTHER Henrietta Savage

11 BIRTHPLACE OF MOTHER (city or town) (State or country) Alexandria Va.

14 Informant Henrietta White

(Address)

15 Filed 2 8 1930, C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1930

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to May 27, 1930, that I last saw h[illegible] alive on May 27, 1930 and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningitis (sp.).

(duration) ____ yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Carroll M St Clair, M. D.

. 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 5/28/1930

ADDRESS

20 UNDERTAKER Wm. Geo. H. Holland 1631 Druid Hill

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57559 32 E 57559

CERTIFICATE OF DEATH

REGISTERED NO. 16-67

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Adelaide Mainster

(a) RESIDENCE NO. 3213 Belmont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Samuel P. Mainster

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mildred Haywood

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs. Samuel P Mainster

(Address) 3213 Belmont Ave

15 Filed ..... 19 C. HAMPSON JONES, Registrar

NOV 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1930, to May 27, 1930, that I last saw her alive on May 27, 1930 and that death occurred, on the date stated above, at 5.25 p m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningitis
(Tuberculous)

(duration) yrs. 1 mos. da.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical - Autopsy - Puncture

(Signed) Myron G Tull, M. D.

5/28, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem — DATE OF BURIAL May 28 19 30

20 UNDERTAKER Easton Sons — ADDRESS Elkton City

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57560 HEALTH DEPARTMENT—CITY OF BALTIMORE 42 57560

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. St Joseph's Hospital ST.) 9-17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wade H. Knight

(a) RESIDENCE NO. Grasonville Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Addie C. Knight

6 DATE OF BIRTH (month, day, and year) Feb. 16 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ruth F. Knight

(Address) Grasonville Md

Filed ....., 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-27-30

17 I HEREBY CERTIFY, That I attended deceased from 5-16, 1930, to 5-27, 1930, that I last saw him alive on 5-27-, 1930, and that death occurred, on the date stated above, at 7 10 A.m.

The CAUSE OF DEATH* was as follows:

Bronchiectasis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) General toxaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray - Clinical

(Signed) M. Goudsky, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grasonville, Md.	May 28-1930
UNDERTAKER	ADDRESS
Horace F. Burgee	3631 Falls Road

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57561

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57561

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 3400 Hickory Ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hiram F. Seal

(a) RESIDENCE NO. 3400 Hickory Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara E. Seal

6 DATE OF BIRTH (month, day, and year) March 13-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Seal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Caroline Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Barbara E. Seal

(Address) 3400 Hickory Ave.

15 Filed MAY 28 1930 C. HARRISON, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27-1930

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to May 27, 1930, that I last saw him alive on May 23rd, 1930 and that death occurred, on the date stated above, at 140 P. m.

The CAUSE OF DEATH* was as follows:

Advanced Cardio-Vascular Renal disease

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Routine

(Signed) [illegible], M. D.

May 28, 1930 (Address) 850 W 36 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ivy Hill, Laurel, Md.	May 30 1930.
20 UNDERTAKER Horace F. Burgee	ADDRESS 3631 Falls Road

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57562 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57562

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. 416 Cathedral St. 10-14 WARD) 100.00

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bartholomew St Leger

(a) RESIDENCE NO. 1209 Vanay ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary St Leger

6 DATE OF BIRTH (month, day, and year) Aug 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS
10 NAME OF FATHER John St Leger
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Mary Twohy
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) John St Leger 1219 E Fayette Ave

Filed MAY 20 1930, 19 C. HAMPSON JONES, M. D.
By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-27-30

17 I HEREBY CERTIFY, That I attended deceased from 5-23-30, 19..., to 5-27-30, 19...,
that I last saw him alive on 5-27-30, 19...,
and that death occurred, on the date stated above, at 1:30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Collapse
(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of No
Was there an autopsy? No
What test confirmed diagnosis? Clinical Course
(Signed) J B Sudrey, M. D.
, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL May 30 1930

UNDERTAKER Rita Wriedfeld — ADDRESS 914 Fremont Ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

(Fiske)

E 57563

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-E 57563

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 - East 30th ST., 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Fiske

(a) RESIDENCE NO. 1602 - East 30th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie May Wilson Fiske

6 DATE OF BIRTH (month, day, and year) Dec 17th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	5	11 10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Wholesale Corp

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Henry Fiske

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hilge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jennie May Wilson Fiske

(Address) 1602 East 30th Street

15 Date 5 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27th 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1930, to May 27th, 1930, that I last saw h/m alive on May 27th, 1930, and that death occurred, on the date stated above, at 5350 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Personal observation

(Signed) Wm Conrad Bode, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 5/30/1930

20 UNDERTAKER Wm. Hilton & Son — ADDRESS 2503 Edmondson

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57564

CERTIFICATE OF DEATH.

91-E 57564

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 30 E. Montgomery St. 97-35 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Hammel

(a) RESIDENCE NO. 30 E. Montgomery ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 78 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Hammel

6 DATE OF BIRTH (month, day, and year) May 9. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Catherine Geigler
(Address) 30 E. Montgomery St

15 Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1930, to May 26, 1930,
that I last saw h alive on May 26, 1930
and that death occurred, on the date stated above, at 9.55 P m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) —

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. C. Conser, M. D.

5/27, 1930 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 29 1930

20 UNDERTAKER Margaret B. Flynn ADDRESS 1422 Eight St.

MAY 28 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 57565

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57565

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 N. Chester ST. 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Elizabeth Ritz (Ritz)

(a) RESIDENCE NO. 828 N Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Ritz

6 DATE OF BIRTH (month, day, and year) March 6. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Sylvester Spiegel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Ritz

(Address) 828 N. Chester st

15 Filed 2-8-1930 C. HAMPSON JONES M. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1930

17

I HEREBY CERTIFY, That I attended deceased from May 16, 1930, to May 26, 1930, that I last saw her alive on May 25, 1930 and that death occurred, on the date stated above, at 6:25 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 3 yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. of heart & pulse

(Signed) Hiram Freed, M. D.

, 19 (Address) 816 Medical arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 30 1930
20 UNDERTAKER	ADDRESS
William G. Schaffer	816 Fremont

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 57566

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

E 57566

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Md. Gen. Hosp. ST. 15-61 (WARD)

2-FULL NAME Miss Hannah W. Lester

(a) RESIDENCE NO. 3602 Clifton Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None.

6 DATE OF BIRTH (month, day, and year) Sept-7-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Maryland.

PARENTS

10 NAME OF FATHER Thomas Lester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Md

12 MAIDEN NAME OF MOTHER Christiana Wiley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. Md.

14 Informant Hospital Record
(Address)

15 2 8 1930 C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1930, to May 27, 1930, that I last saw her alive on May 27, 1930, and that death occurred, on the date stated above, at 5:00 p. m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis.

(duration) ..... yrs. 1 mos 1 ds.

CONTRIBUTORY (Secondary) Cardiac Dil.

(duration) ..... yrs. ..... mos. 1 hrs. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) 5/27/30 Jno. A. Hampton, M. D.

Address 3602 Clifton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 5/30 1930

20 UNDERTAKER: Henry W. Mears — ADDRESS: 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57567

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 57567

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2536 Hollins Ferry Rd. ST. 25 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louisa Smith

(a) RESIDENCE NO. 2536 Hollins Ferry Road ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Smith

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years: 52 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Salisbury N C

PARENTS

10 NAME OF FATHER: Wm Taylor Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): [illegible] N C

12 MAIDEN NAME OF MOTHER: Emily Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Salisbury N C

14 Informant: Jacob Smith (Address): 2536 Hollins Ferry Rd

15 Filed: 28 1930, C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/25/30

17 I HEREBY CERTIFY, That I attended deceased from 2/19/30, to 5/25/30, that I last saw her alive on 5/23/30, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Hawkins M. D.

May 26 1930 (Address) 912 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem | DATE OF BURIAL: May 27 1930

20 UNDERTAKER: Samuel L. Hamilton | ADDRESS: Ridgely

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57568

90 E 57568

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 17-24 Ward)

2-FULL NAME William Heggie

(a) RESIDENCE NO. 922 Druid Hill Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colord	Widowr

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) April-1884

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Pullman Co. 621

9 BIRTHPLACE (city or town)
(State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Ernest Heggie
(Address) 922 Druid Hill Ave.

15 Filed 2-8 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

5/28, 1930, (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greensboro N.C.

DATE OF BURIAL May 28 1930

20 UNDERTAKER Samuel H. Hemsley

ADDRESS 578 N. Eutaw

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 57569

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57569

CERTIFICATE OF DEATH.

X 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen'l Hospital St. 11-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Mack

(a) RESIDENCE NO. Pikesville, Md-Route 20 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15: 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER David Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md Annie Collins

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records
(Address)

15 Filed MAY 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1930

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1930, to May 27, 1930, that I last saw him alive on May 27, 1930, and that death occurred, on the date stated above, at 10 50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinomatosis, Phlebitis, Embolism (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 5, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

5/28/30 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Pleasant Cemetery	May 31 1930

20 UNDERTAKER ADDRESS

J. F. Ehrie Rentzelow

Spec.—1-30—M. & T.—250 Bks.

John Mc Connell

E 57570

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57570

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6-9 ST., WARD)

2-FULL NAME John McConnell

(a) RESIDENCE NO. 105 N. Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Hester

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or estsblishment in which employed (or employer) O H O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Sam ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 5-26, 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-25-30

17 I HEREBY CERTIFY, That I attended deceased from 5-19-30, 19..., to 5-25-30, 19...,

that I last saw h... alive on 5-25-30, 19...,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Lusheed Pneumonia 5 Touch

over

(duration) ...yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Syphilis, Tertiary

(duration) ...yrs. ...mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & W.R.

(Signed) Warren McPhee Lam, M. D.

5-26, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Health Commissioner

ADDRESS MAY 28 1930

FOR WM. F. WOOD

SECTION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57571

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2732 W. Fairmount St. (WARD) 20-69

REGISTERED NO. 1614 E 57571

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Poleto

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Aug 27-30

7 AGE — Years — Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Costa Poleto

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece

12 MAIDEN NAME OF MOTHER: Fanoula Samatiego

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greece

14 Informant (Address)

15 AUG 28 1930 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1930, to Aug 27, 1930, that I last saw h[illegible] live on Aug 27, 1930, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Forward wall

Miscarriage (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

19 (Address) 1450 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS MAY 28 1930

PAT. WM. E. WOODALE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-29—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57572 E 57572

CERTIFICATE OF DEATH.

X 146

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No.) 4-30 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgia Johnson

(a) RESIDENCE NO. Randallstown Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of L. Clayton Johnson

6 DATE OF BIRTH (month, day, and year) Oct 28-1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home 037

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Summer Pickett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown Slave

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant L. Clayton Johnson

(Address) Randallstown

15 Filed 2 6 1930 C. HAMPSON JONES, M. D. Registrar.

For MCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-28 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-24, 1930, to 5-28, 1930, that I last saw her alive on May 28, 1930, and that death occurred, on the date stated above, at 4:50 P.m.

The CAUSE OF DEATH* was as follows:

Post Partum infection

Streptococcus hemolyticus septicaemia; general peritonitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory & Clinical

(Signed) E. W. Payne, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt View DATE OF BURIAL 5/31 1930

20 UNDERTAKER Wm Cook ADDRESS 1217 W Saratoga St

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 57573 ✓ E.67573.

E 57573 E 57573

HEALTH DEPARTMENT—CITY OF BALTIMORE

154-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Mem. Hosp. ST. 18-26 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert LeRoy Johnson

(a) RESIDENCE NO. 1206 N. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Balt.
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Johnson

11 BIRTHPLACE OF FATHER (city or town) Balt.
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Mrs. Edward Johnson.
(Address)

15 Filed on ..... 19.....
C. HAMPSON JONES, M. D.
By ..... Registrar

MAY 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27-1930

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1930 to May 27, 1930, that I last saw him alive on May 27, 1930, and that death occurred, on the date stated above, at 9 10 P m.

The CAUSE OF DEATH* was as follows: (Primary Cause)

Premature birth and congenital malformation of heart (patent foramen ovale) (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy + Examination

(Signed) W. K. Swafford, M. D.

19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters

DATE OF BURIAL 5/29 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Pratt St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57574

91-002 E 57574

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2232 Eastern Ave ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Magdalena Ulatowska

(a) RESIDENCE NO. 2232 Eastern Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Gapczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Ulatowski

(Address) 2232 Eastern Ave

15 Filed ..... 19..... C. HAMILTON JONES, M. D.
Registrar
By

MAY 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. — 19 29 to May 27 19 30

that I last saw her alive on May 26 19 30

and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Senility

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G. H. D. Gibson, M. D.

, 19 (Address) 1128 S. Gilmor St. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	May 31 1930

20 UNDERTAKER John McFadden 401 S. ADDRESS Greene St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57575

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 E 57575

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1918 E Pratt ST. 2-4 WARD)

2—FULL NAME Genevieve Jakubowski

(a) RESIDENCE NO. 1918 E Pratt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Chester Jakubowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sophia Benska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Chester Jakubowski
(Address) 1918 E Pratt St.

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

MAY 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1930

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1930, to May 28, 1930, that I last saw her alive on May 28, 1930 and that death occurred, on the date stated above, at 10A. m.

The CAUSE OF DEATH* was as follows:

Acute Nasal

(duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William A. Daneb M. D.

19 (Address) 801 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairview Cem	May 29 1930
20 UNDERTAKER John M. Weber	ADDRESS 401 E Chase St

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 57576 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57576

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 Sharp ST 22-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Gray Jr.

(a) RESIDENCE NO. 501 Sharp ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 3, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	26 25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Geo. T. Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Gladys Ammons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Geo. T. Gray (Address) 501 Sharp St

15 Filed 2 9 1930 C. HAMPSON JONES, M. D. Registrar No. 2006

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28. 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 25 , 1930 , to May 28 , 1930 , that I last saw h[illegible] alive on May 28 , 1930 , and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) Cold

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. P. Strong , M. D.

, 19 (Address) 506 Hanover st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 5/30/1930

20 UNDERTAKER Wm Cook 1217 ADDRESS St Paul St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57577

E 57577

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4907 Grindon Ave ST., 27-47 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Joseph Wolf

(a) RESIDENCE NO. 4907 Grindon Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alvina Wolf

6 DATE OF BIRTH (month, day, and year) Mar 28-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) (General)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Matteson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Alvina Wolf

(Address) 4907 Grindon Ave

15 Filed MAY 29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to May 27, 1930, that I last saw h alive on May 26, 1930, and that death occurred, on the date stated above, at 4 [illegible] a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam B Lemmon, M. D.

(Address) 718 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel

DATE OF BURIAL May 30 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eutaw

IMPORTANT—See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57578

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57578

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 16-21 WARD)

2—FULL NAME George C. Kraft

(a) RESIDENCE NO. 1933 Ridgehill Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 29, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	5	1 29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Albert Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Marie Meagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs. Albert Kraft
(Address) 1933 Ridgehill Ave.

15 Filed ....., 19 .....
Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1930

17

I HEREBY CERTIFY, That I attended deceased from May 2, 1928, to May 28, 1930, that I last saw him alive on May 28, 1930 and that death occurred, on the date stated above, at 4 10 p m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

..... (duration) ..... yrs. ..... mos. 33 ds.

CONTRIBUTORY (Secondary) Streptococcic Septicemia

..... (duration) ..... yrs. ..... mos. 16 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Myron G. Tull, M. D.

5/29. 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	May 30 1930
20 UNDERTAKER	ADDRESS
Josiah Syfer	1600 or Myrtle Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57579

CERTIFICATE OF DEATH

90 E 57579

REGISTERED NO.

1—PLACE OF DEATH 2011 Linden Ave

CITY OF BALTIMORE: (No. Baltimore Md ST. 14-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard E. Watkins

(a) RESIDENCE NO. 2011 Linden Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence H. Dickinson

6 DATE OF BIRTH (month, day, and year) -------- 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Designer

(b) General nature of industry, business, or establishment in which employed (or employer): Lighting Fixtures

(c) Name of employer: --------

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James S. Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Kate T. Gade

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs. Florence H. Watkins

(Address) 2011 Linden Avenue

15 Filed ... 19... G. HARPER JONES, M. D. Registrar

MAY 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from December, 1929, to May 27, 1930, that I last saw him alive on May 27, 1930 and that death occurred, on the date stated above, at 7 15 P m.

The CAUSE OF DEATH* was as follows:

angina pectoris

mitral insufficiency

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) myocardial insufficiency

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? not known.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical, laboratory, X Ray methods

(Signed) Frankl Smith, Jr., M. D.

5/27, 1930 (Address) 9271 Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	5/29 19 30
20 UNDERTAKER	ADDRESS
Harry U. Meeks and Son	803 N. Calvert

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57580

CERTIFICATE OF DEATH.

129

REGISTERED NO. E 57580

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 N. Highland Ave ST., 26 WARD)

2-FULL NAME Caroline Link.

(a) RESIDENCE NO. 417 N. Highland Ave ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Frederick W. Link.

6 DATE OF BIRTH (month, day, and year) June 2nd 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Weyworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Schock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick W. Link.

(Address) 417 N. Highland ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27/30

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1930, to May 27, 1930, that I last saw h alive on May 27, 1930 and that death occurred, on the date stated above, at 5 25 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Int. Nephritis

Hemorrhagic Pneumonia

Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis of Heart (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. G. Marr, M. D.

(Address) 1516 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL First Evangelical Lutheran — DATE OF BURIAL May 30 1930

20 UNDERTAKER Lilly & Geiser Inc. — ADDRESS 403 S. Wolfe St

JUN 2 1930 H. THOMPSON JONES, M. D.

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57581

CERTIFICATE OF DEATH

186-001

E 57581
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No.) Penn R.R. Tunnel St., 8-45 Ward

2-FULL NAME Howard Franklin Thomas

(a) RESIDENCE No. 2863 Chesterfield St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Euttra G. Thomas

6 DATE OF BIRTH (month, day, and year) Dec. 29th 1886

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
43	5	29 28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Penna R.R. 83
(b) General nature of industry, business, or establishment in which employed (or employer) Freight Conductor
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John S. Thomas

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Susie Bratton

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Euttra G. Thomas
(Address) 2863 Chesterfield ave

15 Filed ..., 19... HAMPSON JOHNS, M. D. Registrar

MAY 29 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest find that said deceased came to his death
(Inquest, autopsy or inquiry)
on the day stated above.

The CAUSE OF DEATH* was as follows:
Traumatic Amputations
Penn R R accident

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Shock

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Examination

(Signed) H. H. Glades, M. D.

. 19 (Address) 143 E Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	May 31 1930
20 UNDERTAKER	ADDRESS
Lilly + Geiler Inc	4008 Wolfe

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 57582 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57582

CERTIFICATE OF DEATH

REGISTERED NO. 24-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Eamalton St. 46-E WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mamie Hale

(a) RESIDENCE NO. 1121 Edmalton ST. 46 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	col	Widow

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Geo. Hale

6 DATE OF BIRTH (month, day, and year) — 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Parakie Jones

(Address) 1121 Eutaw ave.

15 Filed 5-29, 1930 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27/30

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to May 27, 1930, that I last saw h alive on May 27, 1930, and that death occurred, on the date stated above, at 7.20 P.M. (D.S.T.)

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edwin Edmonson M. D.

5-29, 1930 (Address) 106 Edmonson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mound Town — DATE OF BURIAL 5-31 1930

20 UNDERTAKER Joseph A Lively — ADDRESS 4045 Mondat

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57583

CERTIFICATE OF DEATH

14-001

E 57583

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1016 Shield St., 17-24 Ward)

2-FULL NAME Milton Lee Board.

(a) RESIDENCE NO. 1016 Shield St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col'd

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Z

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE: Years 45 | Months | Days | IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040
(c) Name of employer

9 BIRTHPLACE (city or town) Augusta Ga.
(State or country)

PARENTS

10 NAME OF FATHER John H. La Board

11 BIRTHPLACE OF FATHER (city or town) Ga.
(State or country)

12 MAIDEN NAME OF MOTHER Mathews

13 BIRTHPLACE OF MOTHER (city or town) Ga.
(State or country)

14 Informant Tracy La Board
(Address) 1016 Shield

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 26th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible], M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: 5-29 1930

20 UNDERTAKER: Joseph A. Lively 419 N Mount St. — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 29 1930

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57584

CERTIFICATE OF DEATH.

129 E 57584

1-PLACE OF DEATH — REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO. Mt Hope Retreat ST. 28-63 (WARD)

2-FULL NAME Joseph Zunkellar

(a) RESIDENCE NO. Mt Hope Retreat ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Unk

6 DATE OF BIRTH (month, day, and year) Feb 3 1868

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	62	3	23 25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unk

(b) General nature of industry, business, or establishment in which employed (or employer) Unk

(c) Name of employer Unk

9 BIRTHPLACE (city or town) Unknown
(State or country) Germany

PARENTS

10 NAME OF FATHER Daniel Zunkellar

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Germany

14 Informant Mt Hope Records
(Address) Mt Hope Retreat

15 Filed ..... 19 ..... Registrar .....

MAY 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1925 to May 28, 1930, that I last saw h[e] alive on May 28, 1930, and that death occurred, on the date stated above, at 12-20 noon m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis
Chr. Interstitial Nephritis

Unknown (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Dementia Unknown
(duration) 40 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Bell, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Catholic Cemetery	May 30, 30
20 UNDERTAKER	ADDRESS
Stewart & Co	Baltimore

TION IS very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57585

E 57585

CERTIFICATE OF DEATH.

+ 49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 7-13 WARD)

2-FULL NAME Mr August Kohn

(a) RESIDENCE NO. Columbia S.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of Irma Kohn

6 DATE OF BIRTH (month, day, and year) Feb 22 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broker

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Country S.C.

PARENTS

10 NAME OF FATHER Theodore Kohn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dr Theodor Kohn

(Address) Columbia S.C.

15 Filed 5-29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-29-30

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1930, to May 29, 1930, that I last saw him alive on May 29, 1930, and that death occurred, on the date stated above, at 8:05 A. m.

The CAUSE OF DEATH* was as follows:

1. Post operation Shock

1. Hyper nephroma

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

P. O. Shock (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 27, 1930.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. E. Friedman, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Columbia S. C.

DATE OF BURIAL May 29 1930

20 UNDERTAKER H. Rosenthal & Son

ADDRESS 1802 Eutaw Pl

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 57586

HEALTH DEPARTMENT—CITY OF BALTIMORE

94-902 E 57586

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 216 N. Chester ST., 6-9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin W. Simpson

(a) RESIDENCE No. 216 N. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Sophia Simpson

6 DATE OF BIRTH (month, day, and year) July 11 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper at 015

(b) General nature of industry, business, or establishment in which employed (or employer) Penna R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John R. Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. W. Simpson

(Address) 216 N. Chester St.

15 Filed , 19 Registrar

C. HAAS, Jr. Registrar

2 9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26/30

17 I HEREBY CERTIFY, That I attended deceased from May-14-, 1930, to May 26-, 1930, that I last saw h. alive on May 26-, 1930, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Senile-Sub Acute Bronchitis

(duration) yrs. 16 14 ds.

CONTRIBUTORY (Secondary) Senile - Partial Failure

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Frank E Bruner, M. D.

, 19 (Address) 125 E. Broadway —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem.

DATE OF BURIAL May 29 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57587 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57587

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD) 11-24

2-FULL NAME Wm Francis

(a) RESIDENCE NO. 314 W Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie

6 DATE OF BIRTH (month, day, and year) 3-10-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65 60		2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caretaker

(b) General nature of industry, business, or establishment in which employed (or employer) 0516

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Francis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records (Address)

15 Filed MAY 29 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-27-30

17 I HEREBY CERTIFY, That I attended deceased from 5-20, 1930, to 5-27, 1930, that I last saw him alive on 5-27, 1930, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy Prostate

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerotic C.V. disease

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyko, M. D.

5/27, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 5/30, 1930

20 UNDERTAKER Jesse H. Redden

ADDRESS 436 W. Biddle St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 57588 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57588

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3209 Eastern Ave. ST., WARD) 1-2

2-FULL NAME Francis L. Whitaker

(a) RESIDENCE No. 3209 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Whitaker

6 DATE OF BIRTH (month, day, and year) Oct. 22-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hochschild, Kohn&Co.

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Whitaker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Penna.

12 MAIDEN NAME OF MOTHER Anna Bailey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Mary L. Whitaker
(Address) 3209 Eastern Ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27- 1930, to May-27- 1930, that I last saw h— alive on May-27- 1930, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Malig. Dis - Liver -

(duration) 3 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) Frank C Bramble, M. D.

, 19 (Address) 125 S. Broadway -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL May 31 1930

20 UNDERTAKER George N. Zinkler

ADDRESS 1737 E. Eager st.

Y 29 1930 C. HARRY JONES, Registrar

TION IS very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 57589 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57589

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 100 S. Wilfland ST., WARD) 20-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Stettmeier

(a) RESIDENCE No. 100 S. Wilfland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Stettmeier

6 DATE OF BIRTH (month, day, and year): January 1860

7 AGE — Years: 69 — Months: 11 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): in Cross St. Market

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John Stettmeier

(Address) 100 S. Willand St.

15 Filed MAY 29 1930, 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27 1930

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1929, to May 27, 1930,

that I last saw him alive on May 27, 1930,

and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Arteriosclerosis Gangrene Foot

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj. O'Mc Cleary, M. D.

(Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Ext Cemetery — DATE OF BURIAL: May 30 1930

20 UNDERTAKER: George L. Schabel & Sons — ADDRESS: Eutaw & Lanvale Sts.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57590

CERTIFICATE OF DEATH

46

E 57590

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1533 Ramsay ST., WARD) 19-21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha May Robinson

(a) RESIDENCE NO. 1533 Ramsay ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Robinson

6 DATE OF BIRTH (month, day, and year): May 10, 1886

7 AGE: Years 44 | Months | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: James F. Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Dora Dufour

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Thomas H. Gray

(Address) 640 S. Fenton Ave. attending Clinic U. of M.

15 Filed 5-29-1930, by HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): MAY 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 29, 1930, to May 27, 1930

that I last saw h alive on May 26, 1930

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma from Carcinoma of Uterus.

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Atlantic City, N. J.

Did an operation precede death? Yes Date of July 1929

Was there an autopsy? No

What test confirmed diagnosis? Laboratory reports findings

(Signed) Dr. Barrett M. D.

5/28/30 (Address) 2229 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem.

DATE OF BURIAL: 5/30 1930

20 UNDERTAKER: Harry A. Nitzke, 4101 Edmondson Ave.

ADDRESS

Duplicate. See instruction on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57591

CERTIFICATE OF DEATH 198

E 57591

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 715 W. Saratoga St., Ward) 4-26

2-FULL NAME Luther Booze

(a) RESIDENCE NO. 715 W. Saratoga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Single (?)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant
(Address)

15 Filed ....., 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Auto psy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to Hes death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorhage due to stab wound of heart. Homicide. Stabbed w ice pick.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Auto psy.

(Signed) Eugene Feldgut, M. D.

5/24, 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS MAY 29 1930

Deputy Commissioner Health

C. HAMPSON JONES, M. D. MAY 29 1930

Per Wm E. WOODALL

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57592

CERTIFICATE OF DEATH

191 E 57592

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Giles

(a) RESIDENCE NO. 1420 Unknown St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE: Years About 85 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer) 887
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant N. W. Police Pens
(Address)

15 Filed , 19 Registrar

MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide

Lobar Pneumonia

(duration) 1 yr. mos. 3 da.

CONTRIBUTORY (Secondary) Gun shot wound Right Arm

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death? Rear 400 Block Bill

Did an operation precede death? Yes Date of May 15

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic Exam

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAY 29 1930

Commissioner Health

HARPER HOUSE

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 57593 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57593

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... St., ... Ward)

2-FULL NAME Dorothy James

(a) RESIDENCE NO. 1717 W. Lexington St., 19-27 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 5 - 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Foster James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Alma Osborne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-25-1930

17 I HEREBY CERTIFY, That I attended deceased from May-10, 1930, to May 25, 1930, that I last saw her alive on May 25, 1930, and that death occurred, on the date stated above, at 3¹⁰ A m.

The CAUSE OF DEATH* was as follows:

Ile - pulmonary.

(duration) ..... yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of No

Was there an autopsy? Yes.

What test confirmed diagnosis? X-ray.

(Signed) J. Bridgford M. D.

5/28 19/30 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

UNDERTAKER (Jos. Commissioner Health.

ADDRESS MAY 29 1930

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57594 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57594

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH Johns Hopkins Hospital.

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 6-9

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Curtis

(a) RESIDENCE NO. 1632 E. Fayette ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25, 1930

7 AGE Years ..... Months ..... Days 1 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER Ida Curtis

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va.

14 Informant H. G. Douglas (Address) Johns Hopkins Hospital

15 Filed May 29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1930, to May 26, 1930

that I last saw her alive on May 26, 1930

and that death occurred, on the date stated above, at 8:56 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. G. Douglas, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

UNDERTAKER Commissioner Health

ADDRESS MAY 29 1930

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 57595 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57595

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 N. Paca St. ST., 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis M. Miller

(a) RESIDENCE NO. 514 N. Paca St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of George Miller

6 DATE OF BIRTH (month, day, and year) April 13, 1861

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	1	15 16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Schiure

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary Topost

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Bernard Schiure
(Address) 102 S. Carrollton Ave

15 Filed MAY 29 1930 19 C. HAMPSON JONES, M.D.
Registrar
Per R.C.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 29, 1930, that I last saw h[illegible] alive on May 28, 1930, and that death occurred, on the date stated above, at 5-15 9 m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) ..... yrs. unknown mos ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) unknown yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No What test confirmed diagnosis? Typhoid Sym. & Test

(Signed) W. McDaddy M. D.

, 19 (Address) Medical Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 6/2 1930

20 UNDERTAKER Frederick A. Cole

ADDRESS 1200 N. Fremont Ave

FROM is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 57596

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57596

CERTIFICATE OF DEATH. 122-002

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. ..... ST., 20-27 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Sommers

(a) RESIDENCE NO. 1910 West Mulberry ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Aug 3. 1914

7 AGE 15 Years | Months 9 | Days 24 | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Tubens F. Sommers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mamie Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York N.Y.

14 Informant Mrs Minnie Kempe (Mother)

(Address) 1910 West mulberry St

15 Filed MAY 29 1930 19 C. HAMPSON JONES, M. D. Registrar

P. .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1930

17 I HEREBY CERTIFY, That I attended deceased from 5/20 .1930. to 5/27 .1930.

that I last saw h[illegible] alive on 5/27 .1930.,

and that death occurred, on the date stated above, at 10 55 a.m.

The CAUSE OF DEATH* was as follows: [illegible]

Hepatic cirrhosis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) George Brewer, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetary

DATE OF BURIAL 5/30/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57597 E 57597

CERTIFICATE OF DEATH

7-11 90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2830 E. Madison ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amos J. Sexton

(a) RESIDENCE NO. 2830 E. Madison ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah J. Sexton

6 DATE OF BIRTH (month, day, and year) March 1 1874

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56	2	28 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman Water Dept.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Penn Pa.

PARENTS

10 NAME OF FATHER James F. Sexton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. J. Sexton

(Address) 2830 E. Madison St

15 Date 2 9 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to May 28, 1930, that I last saw h.. alive on May 27, 1930 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus. Chronic Endocarditis Arteriosclerosis Hypertension (duration) ✓ yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alan B Lemmon, M. D.

5/29, 1930 (Address) 718 W Pattenson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	May 31 1930
UNDERTAKER	ADDRESS
John C. Miller	2435 E Oliver St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57598

CERTIFICATE OF DEATH

100-00 E 57598

1-PLACE OF DEATH

REGISTERED NO. 15-58

City of BALTIMORE: (No. 3940 Park Hts Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence E Johnson Jr.

(a) RESIDENCE NO. 3940 Park Hts Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28/29

7 AGE Years 8 Months Days 1 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Clarence E Johnson

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Edna Lee

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Mrs Clar. E. Johnson

(Address) 3940 Park Hts Ave

29 1930 C. HAMPSON JONES, M. D. Registrar

Par —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1930

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1930, to May 29, 1930, that I last saw h[illegible] alive on May 29, 1930, and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions Due to Fatty Heart

(duration) yrs. mos. 4 ds. 6 hrs

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Visible,

(Signed) [illegible], M. D.

May 29 1930 (Address) 1605 N. Wolfe St

*State (the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial May 31, 1930

20 UNDERTAKER Horace F. Burgee — ADDRESS 3631 Falls Rd

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 57599

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57599

CERTIFICATE OF DEATH

7H-001

1-PLACE OF DEATH Jenkins Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE; (No.) 100 E Eaton Ave ST., WARD 14-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Atwell

(a) RESIDENCE NO. 1434 John ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 109

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER William F Atwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Evelyn A Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Jenkins Memorial Hosp (Address) 100 E Eaton Ave

15 Filed 2-9-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1930, to May 28, 1930, that I last saw him alive on 5-28, 1930, and that death occurred, on the date stated above, at 6 00 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL May 31, 1930.

20 UNDERTAKER Martin Baker & Sons

ADDRESS 1877 W Northam

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57600

CERTIFICATE OF DEATH.

E 57600

1-PLACE OF DEATH Md General Hospital 131 REGISTERED NO.

CITY OF BALTIMORE: (No. Howard & Madison ST., WARD) 11-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Allen Somers

(a) RESIDENCE NO. Delta, Pa. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Pollard

6 DATE OF BIRTH (month, day, and year): Jan 7-1866

7 AGE: Years 64 Months 4 Days 22 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer): Remington Arms.

(c) Name of employer Co.

9 BIRTHPLACE (city or town) (State or country): York County Pa

PARENTS

10 NAME OF FATHER: William Somers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D.C.

12 MAIDEN NAME OF MOTHER: Margaret McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): York Co Pa

14 Informant (Address): Hosp Record

15 Filed 2 9 1930 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 1930

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1930, to May 29, 1930, that I last saw him alive on May 29, 1930, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Hydronephrosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Suppurative Cystitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) H. H. Kerfoot, M. D.

5/29, 1930 (Address) Md General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Delta Pa.

DATE OF BURIAL: June 2nd 1930

20 UNDERTAKER: B. C. Hostle

ADDRESS: 1000 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E3 57661 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 0 0E 57601

CERTIFICATE OF DEATH. X 122

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L Proctor

(a) RESIDENCE NO. Macon Ga ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Addie C.

6 DATE OF BIRTH (month, day, and year) aug 4-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Travelling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 066

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS

10 NAME OF FATHER Daniel G.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Martha Dutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

Filed 30 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-29-1930

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to May 29, 1930, that I last saw him alive on May 29, 1930, and that death occurred, on the date stated above, at 9 40 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Post-mortem findings.

(Signed) Hedwig Koenig, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forsyth Ga	May 30 1930
UNDERTAKER	ADDRESS
Jno E Mitchell & Sons	1910 Eutaw Place

IMPORTANT: Very important. See instructions on back of certificates.

Dr. Rennie

Spec.—8-16-29—L. F. S.—100 Bks. Dr Seguid 4409 Leb Hgts Av

E 57602

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57602

CERTIFICATE OF DEATH

44

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1119 Ellicott Drive ST., WARD) 16-67

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Magnolia Highsmith

(a) RESIDENCE NO. 1119 Ellicott Drive ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis R Highsmith

6 DATE OF BIRTH (month, day, and year): Sept 8, 1856

7 AGE: Years 73 | Months 8 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: At Home

9 BIRTHPLACE (City or town) (State or country): Louisville, Ky.

PARENTS

10 NAME OF FATHER: James Carney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ky.

12 MAIDEN NAME OF MOTHER: Jane Whitehurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Louis Highsmith

(Address) 1119 Ellicott Drive

15 Filed 30 1930 C. HARRISON JONES, M. D. Registrar

Ref Gtt

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from 5/29, 1930, to 5/29, 1930, that I last saw h[illegible] alive on 5/29/30 and that death occurred, on the date stated above, at 4 40 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) F. G. Seguine, M. D.

, 19 (Address) Med. Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rocky Mount N.C.

DATE OF BURIAL: 5/30/1930

20 UNDERTAKER: D. Wm Cook

ADDRESS: 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 57603 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 57603

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3114 Weedow ave ST., Fairfield WARD) 25-76

2—FULL NAME Mary Youngbar

(a) RESIDENCE NO. 3114 Weedow ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Otto Wm. Youngbar

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Casimir Kolodziejczyk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Barbara Amezjeski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Otto Wm Youngbar
(Address) 3114 Weedow ave

15 Filed 30 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28-30

17 I HEREBY CERTIFY, That I attended deceased from May 25th 1930, to May 28 1930, that I last saw h... alive on May 27 1930 and that death occurred, on the date stated above, at 4 45 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis 5

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia Hawthorn

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benjamin Cuong, M. D.

19 (Address) 4008 Dayton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cemetery — DATE OF BURIAL May 31st 1930

20 UNDERTAKER Fred A. Rhame son — ADDRESS 7031 Hanover st

Important: For instructions on the back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57604

E 57604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4401 Forest Park Av ST., WARD) 26-65

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman B. Cohen

(a) RESIDENCE NO. 4401 Forest Pk. Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Etta Cohen

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Benj Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant I. Lewis (Address) 1439 E Balt St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1930

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1930, to May 29, 1930, that I last saw him alive on May 29, 1930, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Gangrenous ulcer lower Extremity (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Jacob Cohen, M. D.

5/30, 1930 (Address) 2235 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Wash. Road — DATE OF BURIAL 5-30-30 19

20 UNDERTAKER Jack Lewis, 1439 E Balt St. — ADDRESS

Please write very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 57605

E 57605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13-59 118-002

1-PLACE OF DEATH Levin Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Mrs Fannie Kahn (Cohn

(a) RESIDENCE No. 3510 Auchentroly ter ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Solomon Cohn

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Cohn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Gertrude

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) S. Levin 1439 Aisquith St

15 Filed 3 8 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-29-30

17

I HEREBY CERTIFY, That I attended deceased from April 8, 1930, to May 29, 1930, that I last saw h[illegible] alive on May 29, 1930, and that death occurred, on the date stated above, at 4:20 A. m.

The CAUSE OF DEATH* was as follows:

Int. obstruction - Chronic - thrombosis

Acute

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arthritis & Myocarditis

(duration) ..... yrs. ..... mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/20/30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) C. H. Jones, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington Southern Ave.	May 30 1930
UNDERTAKER	ADDRESS
Jos R Lewis,	1439 Gaith St

How is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57606 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 57606

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2910 Brighton ST., (WARD) 16-67 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Lawrence Riley

(a) RESIDENCE NO. 2910 Brighton ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 7 mos 2 ds. How long in U. S., if foreign birth 49 yrs. 7 mos 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Grace A. Riley

6 DATE OF BIRTH (month, day, and year) October 26 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Drugs

(c) Name of employer Muth Bros. Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. F. Riley

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma J. Johns

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Mrs Grace A. Riley (wife)

(Address) 2910 Brighton St

15 Filed 30 1930, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1928, to May 29, 1930, that I last saw h.. alive on May 29, 1930 and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nitral Insufficiency

(duration) 2 yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. L. Keyser, M. D.

. 19 (Address) Woodworth apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 31 1930

20 UNDERTAKER Stewart & Co. ADDRESS Balto

Spec.—1-30—M. & T.—250 Bks

E 57607 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 57607

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 N. Hilton St. ST., WARD) 16

REGISTERED NO. 67

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah A. Friant

(a) RESIDENCE No. 1613 N. Hilton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Friant

6 DATE OF BIRTH (month, day, and year) Jan. 4- 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Woodbury N. J. (State or country)

PARENTS

10 NAME OF FATHER Elias Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hancock Bridge N. J.

12 MAIDEN NAME OF MOTHER Rachel Dickinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poughkeepsie N. Y.

14 Informant Charles H. Friant

(Address) 1613 N. Hilton St.

15 Filed 3-9-1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-29-30

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1930, to May 29, 1930 that I last saw h~~e~~r alive on May 29, 1930 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Labor pneumonia

(duration) yrs. moe. 10 ds.

CONTRIBUTORY (Secondary) Labor pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter S. Tublett M. D.

May 30, 1930 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Eglinton Cem. Clarksboro N. J.

DATE OF BURIAL May 31 1930

20 UNDERTAKER Harry M. Armacost

ADDRESS 4204 Ridgewood ave

FROM A very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57608 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57608

CERTIFICATE OF DEATH.

3-5 7H-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 248 S. Eden St., ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wolfe Rosenblatt

(a) RESIDENCE NO. 248 S. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachael Rosenblatt

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Rosenblatt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Nathan Rosenblatt (Son)

(Address) 248 S. Eden St.,

15 Filed MAY 30 1930 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29th, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 27. 1930, to May 29. 1930,

that I last saw h— alive on May 27. 1930,

and that death occurred, on the date stated above, at 11 A. m. Standard Time

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteio - Sclerosis

(duration) supposed yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) A. T. Bris, M. D.

May 30. 1930 (Address) 24 E Mony

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL May 30 1930

20 UNDERTAKER Jack Levin

ADDRESS 1439 E Baltimore St

How to be very important. See instructions on back of certificate.

Spec.—1-10.21—M&T—1500 Bks.

E 57609

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57609

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 324 Calhoun ST., WARD) 15-22

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Bolton

(a) RESIDENCE NO. 324 Calhoun ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Bolton

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE — Years: 55 — Months: — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Nancy Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Bolton

(Address): 695 S. Fremont Ave

15 Filed ..., 19... C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1930

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1930, to July 28, 1930, that I last saw h[illegible] alive on July 27, 1930, and that death occurred, on the date stated above, at 11 A.M. m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Angina Cord

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. C. Elder, M. D.

19 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 5-28-30

20 UNDERTAKER: Edward Carlson

ADDRESS: Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57610 — 4-25 — E 57610

CERTIFICATE OF DEATH

REGISTERED NO. 4129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 514 Tyson St., (Ward)

2-FULL NAME Rodney Fletcher

(a) RESIDENCE NO. 514 Tyson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Ala.
(State or country)

PARENTS

10 NAME OF FATHER Rodney Fletcher Jr.

11 BIRTHPLACE OF FATHER (city or town) Ala.
(State or country)

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) Ala.
(State or country)

14 Informant Horace Fletcher
(Address) 1423 Winchester

15 Filed ....., 19.... Registrar

MAY 30 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ala.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible] M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	5-30 1930
20 UNDERTAKER	ADDRESS
Dent Carter	89 cc

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 57611

E 57611

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3-5 762

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Salvi Bontempo

(a) RESIDENCE NO. 1103 E. Pratt St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 28th 1930

7 AGE: Years ..... Months ..... Days 1 If LESS than 1 day ..... hrs. or ..... min. 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Samuel Bontempo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Teresa Distefano

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: H. Y. Douglas

(Address): Johns Hopkins Hospital

15 Filed MAY 30 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 28th, 1930, to May 29th, 1930, that I last saw him alive on May 29th, 1930, and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Pleuritis carnea

Maternal pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. Y. Douglas, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: May 30 1930

20 UNDERTAKER: Wendell F. Wiegand

ADDRESS: 3004 Eden

Keep very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Stephen Szewczka

HEALTH DEPARTMENT—CITY OF BALTIMORE

57612

CERTIFICATE OF DEATH

168-3

E 57612

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2909 Hudson st. St., Ward)

2-FULL NAME Stephen Szewczyk

(a) RESIDENCE NO. 2909 Hudson Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Maryannn Szewczyk

6 DATE OF BIRTH (month, day, and year) Sept 18th 1892 October 7th, 1886

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	37	8	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedor
(b) General nature of industry, business, or establishment in which employed (or employer) 074
(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER Joseph Szewczyk

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Maryanna Szewczyk
(Address) 2909 Hudson st.

15 Filed 19 C. HAMILTON JONES, M. D. Registrar

MY 30 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Hanging

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

What duration preceded death? Date of

Was there an autopsy?

What test confirmed diagnosis?

May 30 1930

(Signed) C. Hamilton Jones, M. D.

(Address) 437 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery DATE OF BURIAL June 2. 1930

20 UNDERTAKER George a. Weber ADDRESS 706 S. Ann st.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

Cecil O. Phillips, Jr.

E 57613

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57613

CERTIFICATE OF DEATH.

X 4-30

109-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

2-FULL NAME Cecil O. Phillips Jr.

(a) RESIDENCE No. Bel Air Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5		30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bel Air (State or country) Md

PARENTS

10 NAME OF FATHER Cecil Phillips

11 BIRTHPLACE OF FATHER (city or town) West (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bennie Tuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Cecil Phillips (Address) Bel Air Md

15 Filed 6-1 1930, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30th 1930

17

I HEREBY CERTIFY, That I attended deceased from May 23rd, 1930, to May 30th, 1930, that I last saw him alive on May 30th, 1930, and that death occurred, on the date stated above, at 5 25 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis - Acute.

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Signs and Laboratory tests.

(Signed) Henry Dillrich, M. D.

, 19 (Address) Forest Park Bel Air

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	June 1 1930
UNDERTAKER	ADDRESS
Dean & Foster	Bel Air Md

THIS is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 57614

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57614

CERTIFICATE OF DEATH

8-45 49

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1646 Clifton ave ST., ... WARD)

2—FULL NAME William C Rogers

(a) RESIDENCE NO. 1646 Clifton ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 DATE OF BIRTH (month, day, and year) Dec 25th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Maker 8 $

(b) General nature of industry, business, or establishment in which employed (or employer) Dixon Bartlett Co

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Virginia

14 Informant Emma V. Rogers

(Address) 1646 Clifton ave

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

NOV 30 1928

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/29/30.

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to 5/29, 1930; that I last saw h— alive on 5/29, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of left Humerus.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes. Date of About 1 yr

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Exh.

(Signed) Kyle W. Fidley, M. D.

, 19 (Address) 5703 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL May 31st 1930

20 UNDERTAKER George Schulsinger & Sons

ADDRESS 1502 Mount St

Spec.—1-30—M. & T.—250 Bks.

E 57615

E 57615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17-26 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 Edmondson Ave. ST., WARD)

2-FULL NAME Peter J. Jolley

(a) RESIDENCE NO. 824 Edmondson Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Jolley

6 DATE OF BIRTH (month, day, and year) April-No-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Peter Jolley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Burris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Jolley

(Address) 824 Edmondson Ave

Filed MAY 30 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30/30

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to May 30, 1930, that I last saw him alive on May 30, 1930, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Auto Trauma

(duration) yrs. mos 6 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Cooley, M. D.

, 19 (Address) 824 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL June 1, 1930

20 UNDERTAKER Samuel I. Hawkins

ADDRESS 578 Biddle

Spec.—1-12-23—M&T—500 Bks.

E 57616 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57616

CERTIFICATE OF DEATH.

131

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4-30 WARD)

2-FULL NAME Martha Agnes Magruder

(a) RESIDENCE NO. Nurses Home University Hospital ST., WARD

(Usual place of abode) Baltimore, Md. (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23 years	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Hospital

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Kent Magruder (Address) Washington D. C.

15 Filed [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30th 1930

17

I HEREBY CERTIFY, That I attended deceased from May 8th, 1930, to May 30th, 1930, that I last saw her alive on May 30th, 1930, and that death occurred, on the date stated above, at 9:15 A. m.

The CAUSE OF DEATH* was as follows:

Syphilis.

(duration) yrs. two mos. ds.

CONTRIBUTORY (Secondary) Septicemia. Non hemolytic streptococcus.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs and laboratory tests.

(Signed) Henry T. Mudrick, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hyattsville Md

DATE OF BURIAL May 30, 1930

ADDRESS Hyattsville Md

20 UNDERTAKER T. Gasch's Sons

IMPORTANT—See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57617

E 57617

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7-12 129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 N Lakewood Ave WARD)

2-FULL NAME Frank Kurdna

(a) RESIDENCE NO. 711 N Lakewood Ave St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND (or) WIFE of Josephine Kurdna 1848

6 DATE OF BIRTH (month, day and year) 2/27 1844

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	82	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) retired 4 years

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs Frances Kurdna

(Address) 711 N Lakewood Ave

15 Filed 5-30 1930 19 Mar C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28-1930

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1930, to May 28, 1930, that I last saw h[illegible] alive on May 27, 1930, and that death occurred, on the date stated above, at 11.00 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis Chronic

Interstitial Nephritis Marked

Hypertension Myocarditis

(duration) yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Thos. H. Stone, M. D.

May 29, 1930 (Address) 2828 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL May 31 1930

UNDERTAKER John Cosmos

ADDRESS 2998 Eastern

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57618 ✓

E 57618

CERTIFICATE OF DEATH

26-37 182

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Pier No.8 Locust Point. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward T.Dixon.(C)

(a) RESIDENCE NO. 941 S.Baylis St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) January 22, 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	38	4	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore, 674
(b) General nature of industry, business, or establishment in which employed (or employer) Keyway Stevedoring
(c) Name of employer Company.

9 BIRTHPLACE (city or town) Alexandria, Va.
(State or country)

PARENTS

10 NAME OF FATHER Edward H.Dixon.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Carrie Banks.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Edward H.Dixon.(C) father.
(Address) 521 S.Royal St.Alexandria,Va.

15 Filed ..., 19... C. HAMPSON JONES, Registrar

MAY 30 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Occidental fall from a scow.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) H. H. McKennedy, M. D.

5/30, 1930 (Address) 1017 E.Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Alexandria, Va

DATE OF BURIAL May 30, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 57619

E 57619 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 1-3 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2628 Boston ST., 1 WARD)

2-FULL NAME Evelyn Marie Mooney

(a) RESIDENCE No. 2628 Boston ST., 1 WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
X	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John E. Mooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Irene Luckhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John E. Mooney (Father)

(Address) 2628 Boston St.

15 Filed MAY 30 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28/30

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to May 28, 1930, that I last saw her alive on May 28, 1930, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) J. B. Bronushas, M. D.

5-29-30

(Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL May 30 1930

20 UNDERTAKER Lilly & Gilden — ADDRESS 1003 E. Monument

How to be very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 57620

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57620

CERTIFICATE OF DEATH.

X 4-30 159-003

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., ... WARD)

2-FULL NAME Dorothy Miller

(a) RESIDENCE NO. Westminster, Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wade Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mable Bankard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Wade Miller
(Address) Westminster Md

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/29 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-1, 1930, to 5-29, 1930, that I last saw h[illegible] alive on 5/29, 1930, and that death occurred, on the date stated above, at 11.15 a m.

The CAUSE OF DEATH* was as follows:

Cleft Palate since birth- operated on and died of Post-operative shock.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Status Lymphaticus - by autopsy (duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 5/29/30

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) M. C. Garlinghouse, M. D.

5/29, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster — DATE OF BURIAL May 31 1930

20 UNDERTAKER J. H. Bankard & Son — ADDRESS Westminster Md

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57621 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57621

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Rutland Ave St. 7-13 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Bryson

(a) RESIDENCE NO. (Margaret Ave, Essex) 7380 Woodrow Wilson Ave. Detroit Mich.
(Usual place of abode) ST., WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John M. Bryson

6 DATE OF BIRTH (month, day, and year) March 25, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles E. Thon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Teresa Thon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emil Thon
(Address) Margaret Av. Essex

15 Filed ..... 19 ..... Registrar

C. CHAMPION JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-29-30

17 I HEREBY CERTIFY, That I attended deceased from 5/26/30, 19..., to 5/29, 1930, that I last saw her alive on 5/29, 1930, and that death occurred, on the date stated above, at 6:45 P m.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis from Ruptured Tubo-ovarian abscess

(duration) ...yrs. ...mos 5 ds.

CONTRIBUTORY (Secondary) ...

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. E. Baudeman, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Detroit, Michigan

DATE OF BURIAL 6/3/ 1930

20 UNDERTAKER John G. Connelly

ADDRESS Essex Md

FOR INFORMATION ONLY. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

11 / # 57622

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57622

CERTIFICATE OF DEATH

129E 57[illegible]

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3505 Lansdale Ave (5-6-2) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Johns A Ray

(a) RESIDENCE NO. 3505 Lansdale Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Virginia C Ray

6 DATE OF BIRTH (month, day, and year): Jan 1-1845

7 AGE: Years 85 | Months 5 | Days 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolteacher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Easton Md

PARENTS

10 NAME OF FATHER: John B Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Easton Md

12 MAIDEN NAME OF MOTHER: Mary E. Godfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Easton Md

14 Informant: Virginia C Ray

(Address) 3505 Lansdale Ave

15 Filed: MAY 31 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-29-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1925, to May 29, 1930, that I last saw h[illegible] alive on May 28, 1930, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Senile Deterioration)

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hall, M. D.

5/29, 1930 (Address) Wylie cor Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

20 UNDERTAKER: Robert Brooks & Son

DATE OF BURIAL: 5/31 1930

ADDRESS: Calhoun Hollins

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57623

CERTIFICATE OF DEATH

182 E 57623

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore, No. City Home Entrance Reese St. 28th St. 50 Ward

2-FULL NAME Donald J. Moore

(a) RESIDENCE NO. 413 Whitridge Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) June 3, 1917

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	12	11	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer) Boy
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Edmund J. Moore

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Johannah M. Burns

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Elmer J. Moore
(Address) 413 Whitridge Ave.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above. The CAUSE OF DEATH* was as follows:

(a) Drowning
City Home Entrance
28th & Reese-

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What confirmed diagnosis? Yes

Signed 19 G C Wades, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 31, 1930
20 UNDERTAKER Edward W. Conkelin	ADDRESS 924 E. Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. HAMPSON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57624

182 E 57624

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH Sewer - 28th & Reese

City of BALTIMORE: (No. _____ St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Kelly

(a) RESIDENCE NO. 1104 Lafayette St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Jan 11, 1916

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	14	4	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John F. Kelly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Elsie M. Burns

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant John F. Kelly
(Address) 1104 Lafayette Ave

31 1930 C. HARDEN Jones, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, aforesaid find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:*
Accidental
Sewer - 28th Reese
(Primary) (duration) yrs. mos. ds.
Asphyxia
(Secondary) (duration) yrs. mos. ds.

5/30/30 (Signed) G. E. Shader M. D.
(Coroner)

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial May 27 1930

20 UNDERTAKER Elmer W. Conkle ADDRESS 924 E Eager

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57625

CERTIFICATE OF DEATH

46 E 57625

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 N Rose ST., 7-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Mildred Reese

(a) RESIDENCE NO. 705 N. Rose ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 24 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Butte

PARENTS

10 NAME OF FATHER Frederick G. Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary B. Bernard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Frederick Reese

(Address) 705 N Rose St

15 FILED JUN 1 1930 C. HAMPSON JONES, M. D. Registrar By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1930

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1929, to May 28, 1930, that I last saw h[illegible] alive on May 28, 1930 and that death occurred, on the date stated above, at 7.50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Cervix Uteri)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Biopsy

(Signed) Louis Krause, M. D.

, 19 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 31 1930

20 UNDERTAKER Clark Grove Hearse

ADDRESS 906 Linden Ave

Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 57626

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

203
788 E 57626

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Madeline L. Morton

(a) RESIDENCE NO. 2156 North Lambert St Philadelphia Pa. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel Morton

6 DATE OF BIRTH (month, day, and year): July, 30th. 1907

7 AGE: Years 22 Months 10 Days ---

IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Philadelphia Pa

(State or country)

PARENTS

10 NAME OF FATHER: James Leon Scotty

11 BIRTHPLACE OF FATHER (city or town): (State or country) France

12 MAIDEN NAME OF MOTHER: Catherine McWeeny

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Ireland

14 Informant: James L. Scotty

(Address) 2156 N. Lambert St Philadelphia Pa.

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto accident in which she was riding collided with telegraph pole

Duration ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Skull fracture (Co. Dep.) 07

(duration) ....yrs. ....mos. ....ds.

(Signed) ....., M. D.

(Coroner)

AC 5 30 1930 Address 3439 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Patient, Walking at time

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Philadelphia Pa. Date of Burial: May, 31st 30

20 UNDERTAKER: Joseph D Cook ADDRESS 1003 Park Ave

JUN 1930 C. HARPSON JONES, M. D.

Ref

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57627

CERTIFICATE OF DEATH.

182 E 57627

1-PLACE OF DEATH Sewer. 28th & Reese

City of BALTIMORE: (No. ~~Lynedale Park~~ St. 17-50 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Welden

(a) RESIDENCE NO. 400 E. Whitridge St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13 1920

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	9	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.

(State or country)

PARENTS

10 NAME OF FATHER George A. Welden

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Gunning

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Charles Welden

(Address) Ready Ave.

15 [illegible] C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1930

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry find that said deceased came to ~~his~~ death (autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH was as follows:

ACC Drowning

Sewer - 28th & Reese St

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) yrs. mos. ds.

(Signed) G C Staggs M. D.

(Coroner)

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — Date of Burial 5/31 1930

20 UNDERTAKER J. F. McCully — ADDRESS 130 E. Fort

31 1930 Reg. No.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57628

CERTIFICATE OF DEATH

E 57628

REGISTERED NO. 122

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 418. Forrest. ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carmelo Papale

(a) RESIDENCE NO. 418. Forrest ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Filippa Pace

6 DATE OF BIRTH (month, day, and year) April 4th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Antonio Papale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Corso

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Filippa Papale

(Address) 418. Forrest. st.

Filed 5 31 1930, 19 C. HAMPTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29/30

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1930, to May 29, 1930, that I last saw h[illegible] alive on May 26, 1930, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mo. da.

CONTRIBUTORY (Secondary) Bronchitis of Years (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Smerk M. D.

May 30, 1930 (Address) 4786 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 5/31 1930

20 UNDERTAKER Wendell J. Lippard

ADDRESS 300 S. Edwards

Important: See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 57629 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57629

CERTIFICATE OF DEATH. 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 12-19 ST. (WARD)

2-FULL NAME Elise Rentz

(a) RESIDENCE NO. 2006 Guilford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	white	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63 ?	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Artist

(b) General nature of industry, business, or establishment in which employed (or employer) 001

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Rentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Shepherd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Hospital Record

(Address)

15 Filed ..... 19 C. HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-30-30

17 I HEREBY CERTIFY, That I attended deceased from 5-26, 1930, to 5-30, 1930, that I last saw h[illegible] alive on 5-30, 1930, and that death occurred, on the date stated above, at 2'17 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ? ds.

CONTRIBUTORY (Secondary) Arteriosclerosis C V Renal

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

5/30, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount — DATE OF BURIAL June 2 1930

20 UNDERTAKER Henry Hankins Sons — ADDRESS Mc Culloh & Orchard

TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 57630

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57630

CERTIFICATE OF DEATH

REGISTERED NO. 188-703

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Providence Hosp ST. 3-4 (WARD)

2-FULL NAME Theo. Hamner

(a) RESIDENCE NO. 106 S. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Hamner

6 DATE OF BIRTH (month, day, and year) 1892 Dont know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook 021
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant Mrs Estelle Moody (Cousin)
(Address) 106 S. Caroline St

15 Filed 31 1930, 192 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/24/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto in which he was riding collided with Telegraph Pole

(a) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage Head & Face Ruptured (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Morley Ave Co Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Eye Witness

(Signed) L. Hamner, M. D. Coroner

5/24/30 (Address) 1939 W. Eldorado

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL 5-31 1930

20 UNDERTAKER Mrs Chas G. Bailey

ADDRESS 1421 Jefferson

TION is very important. See instructions on back of certificate.

...ing the property examined. Exact statement of OCCUPA-

Cor.—10-10-29—A Co.—100 Bks.

E 57631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 82 E 57631

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore (a) Dower 28 & Reece St., 9-46 Ward)

2-FULL NAME Wilbert Albon

(a) RESIDENCE NO. 446 E 28th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25-1914

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	15	10	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Scholar at School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Harry H. Albon

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country)

12 MAIDEN NAME OF MOTHER Mary L. Farbert

13 BIRTHPLACE OF MOTHER (city or town) Balto City
(State or country)

14 Informant Harry H. Albon
(Address) 446 E 28th St

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Acc Drowning
Dower 28 & Reece
(duration) ... yrs. ... mos. — ds.
CONTRIBUTORY (Secondary) Asphyxia
(duration) ... yrs. ... mos. — ds.

18 Where was disease contracted — —
If not at place of death?
Did an operation precede death? — Date of —
Was there an autopsy? May 30
What test confirmed diagnosis? Autopsy
(Signed) C. G. Glades, M. D.
19 (Address) 143 B Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Grove Balto Co — DATE OF BURIAL May 31 1930

20 UNDERTAKER H S Marshall — ADDRESS 353 Fallsway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

31 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57632

CERTIFICATE OF DEATH

90 E 57632

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1505 Hazel St. Curtis Bay. St. 25-77 Ward)

2-FULL NAME Todose Koval.

(a) RESIDENCE NO. 1505 Hazel St Curtis Bay. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. --mos.--ds. How long in U. S., if of foreign birth? 10 yrs.---mos.---ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Do not know.

6 DATE OF BIRTH (month, day, and year) May 8, 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	49	0	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Anna Cynaniuk.
(Address) 1505 Hazel St. Curtis Bay.

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

31 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency,
Acute Dilatation of the Heart.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto W. Reinhardt, M. D.

5/30, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rusian Independet	Jun 2. 1930
20 UNDERTAKER	ADDRESS
John Grebliauckas	423 S Paca St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 57633 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57633

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. 27245

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 Glenwood Ave ST.) (WARD)

2-FULL NAME William Coward Sr

(a) RESIDENCE NO. 629 Glenwood Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Schlosser

6 DATE OF BIRTH (month, day, and year) 9/15-1840

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
89	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman Wharf Pile Driver

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R. Co

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Casper Goldback (Address) 629 Glenwood Ave

15 Filed 3-1-1930 19 C. HAMILTON JONES, Jr. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28. 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 27, 1930, to May 28, 1930, that I last saw h.... alive on May 27, 1930, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Duncan, M. D.

, 19 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem

DATE OF BURIAL 6/2/30

20 UNDERTAKER Mary T. Ruth

ADDRESS 1235 Hanford

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57634

CERTIFICATE OF DEATH

31 ✓ E 57634

1—PLACE OF DEATH

REGISTERED NO. 9-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1518 E 28th ST., WARD)

2—FULL NAME Caroline Hayes

(a) RESIDENCE NO. 1518 E 28 St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dress cutter

(b) General nature of industry, business, or establishment in which employed (or employer): Ladies House Dresses

(c) Name of employer: A. S. Katzenberg Bros

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John J. Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Constantine Eckert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baden Germany

14 Informant: John J. Hayes Father

(Address): 1518 E 28 St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24-1930

17 I HEREBY CERTIFY, That I attended deceased from January 3, 1930, to May 24, 1930, that I last saw her alive on May 24, 1930, and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Decompensata

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. Fa Stems, M. D.

5/30/30 (Address) 2878 Hartford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: June 2 1930

20 UNDERTAKER: Jos. J. Derr 156 N. Luzerne ADDRESS

J. HAMPTON JONES, M. D.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57635

E 57635

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 W. North Ave. ST. 15-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles H. Wilson

(a) RESIDENCE NO. 1717 W. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Susan E. Kenny

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Henery Wilson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Charles H. Wilson Jr.

(Address) 1717 W. North Ave

15 Filed ..... 19 ..... Registrar

3 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30-1930

17 I HEREBY CERTIFY, That I attended deceased from May 29th, 1930, to May 30, 1930, that I last saw h... alive on May 29th, 1930 and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. H. Jones, M. D.

5/30, 1930 (Address) 720 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woods Chapel Harmonsville Md.	June 4 1930.
20 UNDERTAKER	ADDRESS
Martin Parker & Sons	1827 W. North Ave

C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 57636

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 E 57636

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 W. Franklin St. 14-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henson

(a) RESIDENCE NO. 1707 W. Franklin St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 14, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	43	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer General Constrution Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Callahan

9 BIRTHPLACE (city or town) (State or country) Howard Co, Md.

PARENTS

10 NAME OF FATHER Peter Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. ? Md.

12 MAIDEN NAME OF MOTHER Rosie Thurston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md.

14 Informant Rosie Wicks

(Address) 1707 W. Franklin St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 28th, 19 30, to May 28, 19 30

that I last saw him alive on May 28th. 1930,

and that death occurred, on the date stated above, at 12;30 p m.

The CAUSE OF DEATH* was as follows:

Acct Dilitation of heart

over

(duration) yrs. mos 1 da.

CONTRIBUTORY (Secondary) Cardiac decompensation Mitral and Aetic

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL May 31 1930

20 UNDERTAKER Thomas E. Kelsey

ADDRESS 1303 Presstman St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57637 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57637

CERTIFICATE OF DEATH. 24-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 13-59 WARD

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Lowenthal

(a) RESIDENCE NO. Georgian Court Apts. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 9th. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Lowenthal

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rebecca Goldsmith

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mr. Milton Lowenthal
(Address) Georgian Court Apts.

15 Filed JUN 1 1930 19 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29th. 1930

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1930, to May 29, 1930, that I last saw h[er] alive on May 29, 1930, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? her home

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Leitz, M. D.

5-30 1930 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 6/1/ 1930

20 UNDERTAKER Harris Sandheim & Son

ADDRESS 903 Eutaw Place

REGISTRATION OF DEATHS—SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-30—M. & T.—250 Bks

E 57638 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57638

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19. S. Curley St. 1-2 WARD)

2-FULL NAME Cecilia F. Szeimis (Daley)

(a) RESIDENCE NO. 19. S. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/21/1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frank Szeimis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Josephine Lewinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Laura Dzenk (Address) 300 S. Ellington Ave

15 Filed 3 1 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-28-30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1928, to May 28, 1930, that I last saw h[illegible] alive on May 28, 1930 and that death occurred, on the date stated above, at 1205 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. McDaniel, M. D.

May 29, 1930 (Address) 801 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

UNDERTAKER Wm. J. Kavanagh

DATE OF BURIAL 6/2 1930

ADDRESS 1610 Fulton Ave

Spec.—1-30—M. & T.—250 Blks.

E 57631 E 57630

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto. City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Richard Taylor ST. 23-21 WARD

2-FULL NAME 1043 S. Howard

(a) RESIDENCE NO. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of -

6 DATE OF BIRTH (month, day, and year) June 5, 1897?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
33?	32? 38?	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Alfred

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Kate Fisher

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-28-30

17 I HEREBY CERTIFY, That I attended deceased from 5-27-30, 19..., to 5-28-30, 19...,

that I last saw h in alive on 5-28-30, 19...,

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

More than (duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Rheumatic fever (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History & exam.

(Signed) Paul Padget, M. D.

5-29-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calary Cemtery

DATE OF BURIAL 6/1 1930

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1399 W Hamburg St.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57640 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 90 E 57640

CERTIFICATE OF DEATH

REGISTERED NO. 24-34

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1511 Riverside Ave ST. WARD)

2—FULL NAME Furith F. Brown

(a) RESIDENCE NO. 1511 Riverside Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Brown Sr.

6 DATE OF BIRTH (month, day, and year) Feb. 12 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) A. A. Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Hezekiah Linthicum

11 BIRTHPLACE OF FATHER (city or town) A. A. Co.
(State or country)

12 MAIDEN NAME OF MOTHER Matilda Phillip

13 BIRTHPLACE OF MOTHER (city or town) A. A. Co
(State or country)

14 Informant Guy E. Brown (Son)
(Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-28-30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1929, to May 28, 1930,

that I last saw HER alive on May 28, 1930

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) H. C. Campbell, M. D.

5/31, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetary

DATE OF BURIAL 6/1 1930

20 UNDERTAKER J. Fen McCully

ADDRESS 130 E. Fort

JUN 1 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57641

CERTIFICATE OF DEATH

90 VE 57641

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 10-14 Ward)

2-FULL NAME Mary J. Safford (Stafford)

(a) RESIDENCE NO. 1221 Ensor St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph P. Stafford

6 DATE OF BIRTH (month, day, and year) Jan 18/1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	50	5	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(r) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Ireland

PARENTS

10 NAME OF FATHER John Mcavoy

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Brady

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Joseph P. Brady
(Address) 1221 Ensor St

15 Filed ....., 19.. ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Myocarditis

..... (duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. S. McCann, M. D.

5/31/30 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	June 2 1930
20 UNDERTAKER Rita Riedfield	ADDRESS 1 E Fremont Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57642

CERTIFICATE OF DEATH

91-002 E 57642

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Kelly

(a) RESIDENCE NO. Preston & Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER James Kelly

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Bridget Doran

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston & Valley Sts

15 Filed 3-1-1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31st 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-23, 1930, to 5-31, 1930, that I last saw h[illegible] alive on 5-30, 1930, and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Lucas M. D.

5/31, 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters — DATE OF BURIAL June 2 1930

20 UNDERTAKER Rita Mudgett — ADDRESS 914 Greenmount Ave

Spec.—2-29-28—L. F. S.—500 Bks.

(Austin)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57643

CERTIFICATE OF DEATH

101-901 E 57643

1—PLACE OF DEATH

REGISTERED NO. 15-22

CITY OF BALTIMORE: (No. 1333 Woodyear ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Austin

(a) RESIDENCE NO. 1333 Woodyear ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Austin

6 DATE OF BIRTH (month, day, and year): May 8-1889

7 AGE: Years 40 Months 9 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer 0 40

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ga

PARENTS

10 NAME OF FATHER: Saml Austin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga

12 MAIDEN NAME OF MOTHER: Virgin Austin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ga

14 Informant: Lena Austin

(Address): 1333 Woodyear

15 Filed 31 1930, 19 HAA Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28-30

17 I HEREBY CERTIFY, That I attended deceased from April 20, 19..., to May 28, 1930, that I last saw h... alive on May 28, 1930 and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) ... yrs. 4 mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Alcoholism

(duration) ... yrs. 1 mos. 8 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Geo H Holland, M. D.

5-28 1930 (Address) 508 Lamont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 5/31 1930

20 UNDERTAKER: Jas Geo H Holland

ADDRESS: 1039 Druid Hill Ave

Spec.—1-30—M. & T.—250 Bks.

E 57644

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 57644

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2222 Division ST. 14-59 WARD)

2-FULL NAME Florence Murray

(a) RESIDENCE NO. 2222 Division ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Murray

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or, ...min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Washington DC
(State or country)

PARENTS

10 NAME OF FATHER Frank Lane

11 BIRTHPLACE OF FATHER (city or town) DC
(State or country)

12 MAIDEN NAME OF MOTHER Eliza Lane

13 BIRTHPLACE OF MOTHER (city or town) DC
(State or country)

14 Informant Henry Murray
(Address) 2222 Division

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-29-30

17 I HEREBY CERTIFY, That I attended deceased from 5-27-, 1930, to 5-29-30, 19....,
that I last saw h[illegible] alive on 5-29-, 1930,
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Infectious Carbuncle
of Specific Origen

(duration) ..... yrs. ..... mos. (6) ds.

CONTRIBUTORY (Secondary) Toxaemia (Uremia)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 2222 Division

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M Bonkin, M. D.

, 19 (Address) 1572 Gilmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem. DATE OF BURIAL June 1 1930

20 UNDERTAKER Samuel T Hemsley ADDRESS 678 W Biddle St

Spec.—1-30—M. & T.—259 Blks.

E 57645

E 57645 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO. 16-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1016 Wordyear St. (WARD) 16

2-FULL NAME Isaiah C. Wilmore

(a) RESIDENCE NO. 1016 Wordyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Wilmore

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years 52; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Q & O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co. Md

PARENTS

10 NAME OF FATHER: Charles Wilmore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Wilmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Sarah Wilmore Wife

(Address) 1016 Wordyear St

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27-

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1930, to May 27, 1930, that I last saw h[illegible] alive on May 27, 1930, and that death occurred, on the date stated above, at 8 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine

(Signed) L. C. Johnson, M. D.

, 19 (Address) 2329 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Ann Park Cem

DATE OF BURIAL: 5 31, 1930

20 UNDERTAKER: Samuel A. Housley

ADDRESS: Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57646

E 57646

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 Belvedere ST. 12-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William G. Hill

(a) RESIDENCE NO. 1428 Belvedere ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Hill.

6 DATE OF BIRTH (month, day, and year) June 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gloucester Va

PARENTS

10 NAME OF FATHER John Wm Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Anna Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Anna Hill

(Address) 1428 Belvedere

15 Filed MY 31 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1930, to May 28, 1930, that I last saw him alive on May 28, 1930 and that death occurred, on the date stated above, at 9:48 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis (Chronic)

(duration) Don't know yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

(Address) 1021 Madison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Almond Mt. Gloucester Va

DATE OF BURIAL J 3 1930

20 UNDERTAKER Edward Beaudelot

ADDRESS Middle

Spec.—1-10-21—M&T—1500 Bks.

E 57647 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 57647

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3312 23rd ST. 47-50 WARD)

2-FULL NAME Salamon L. Marshall

(a) RESIDENCE NO. 331 E. 23rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Color

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose Marshall.

6 DATE OF BIRTH (month, day, and year): April 5 1857

7 AGE: Years 43 | Months April | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Painter 650

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Miami Co. Ind.

PARENTS

10 NAME OF FATHER: Asa Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio.

12 MAIDEN NAME OF MOTHER: Lucinda Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ind.

14 Informant (Address): Rose Marshall

15 Filed MAY 31 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1930

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1930, to May 28, 1930, that I last saw him alive on May 28, 1930, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis enlarged heart

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) C Nance, M. D.

, 19 (Address) 1316 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary — DATE OF BURIAL: June 1-1930

20 UNDERTAKER: Mrs. R. H. Elliott — ADDRESS: 1225 Eastlander

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57648

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 57648.

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Crowded Hospital 46-32 WARD)

2—FULL NAME William Jackson

(a) RESIDENCE NO. 1002 Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Jackson

6 DATE OF BIRTH (month, day, and year) Feb 21, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) 074

(c) Name of employer

9 BIRTHPLACE (city or town) Casey Co (State or country) Ky

PARENTS

10 NAME OF FATHER Henry Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Helen Jackson

(Address) 1002 Monroe St

15 Filed JUN 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-28-30

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1930, to May 28, 1930, that I last saw h alive on May 28, 1930 and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hypertension Cardio vascular Disease (duration) about 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Carroll McClean, M. D.

, 19 (Address) Crowded Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	May 31, 1930
20 UNDERTAKER	ADDRESS 322 Schroeder St.
Mrs. Katie R. Williams	

Spec.—1-30—M. & T.—250 Blks

E 57649

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57649

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Mem Hospital (Ward) 9-4-6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Edward Alexander

(a) RESIDENCE NO. 2305 Fremont Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Carrie Alexander

6 DATE OF BIRTH (month, day, and year) Nov 17, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman 061

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Police Dept

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Theodore Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Batt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Wife

(Address) 2305 Fremont Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29/30

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1930, to May 29, 1930, that I last saw h.i.m alive on May 29, 1930, and that death occurred, on the date stated above, at 11.40 P. m. Daylight saving

The CAUSE OF DEATH* was as follows: Bronchopneumonia

Pneumonia - Lobular

(duration) ....yrs. ....mos 1 7 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings X-ray

(Signed) Nicholas Sanfrancesco, M. D.

19 (Address) Union Mem Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wards Chapel Balto Co

DATE OF BURIAL June 1, 1930

20 UNDERTAKER Chenoweth Son

ADDRESS 3615 Chestnut Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 57650

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57650

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 517 E 20th ST., 9-4th WARD)

2—FULL NAME William Hogan

(a) RESIDENCE NO. 517 E. 20th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Hogan

6 DATE OF BIRTH (month, day, and year) Nov 4-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hatter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Patrick Hogan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Nolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret Hogan

(Address) 507 E. 20th St

15 Filed 3 1 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 - 30

17 I HEREBY CERTIFY, That I attended deceased from March, 19 30 to May 30, 19 30,

that I last saw h.... alive on May 27, 19 30

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Pulm. Tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? ✓

What test confirmed diagnosis?

(Signed) Chas F Bloke, M. D.

May 31 1930 (Address) 20 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL June 2 1930

20 UNDERTAKER D. Fred A. Wareham — ADDRESS 703 Hamp St

Spec.—1-30—M. & T.—250 Bks

Mary Patterson Rieby ✓

E 57651 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57651

138

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 11-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. ~~Egerton~~ Rieby (~~Mary~~)

(a) RESIDENCE NO. 1039 St. Paul ST. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Egerton Rieby

6 DATE OF BIRTH (month, day, and year) May 27, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Mr. Wm. Patterson

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Emma Claggett

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Hospital Records (Address)

Filed JUN 2 1930, C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to May 31, 1930, that I last saw h.r. alive on May 30, 1930, and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Salpingitis, chr.

own

(duration) 12 yrs. mos da.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/30/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) M.F. Birely, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fellowcraft Cem. DATE OF BURIAL June 2 1930

20 UNDERTAKER Henry Wenkein & Sons ADDRESS Eschange Pl. & Gay St.

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-30—M. & T.—250 Bks.

E 57652 41 E 57652

235-917

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... St., 1400 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Rosen

(a) RESIDENCE NO. 1826 Pennsylvania Ave WARD 25
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 35 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

8a If married, widowed, or divorced
HUSBAND of
or) ~~WIFE of~~ Rosie

6 DATE OF BIRTH (month, day, and year) Aug 4 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Wolf Hurwich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mildred Marcus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Friend
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31-30

17 I HEREBY CERTIFY, That I attended deceased from Apr. 11, 1930, to May 31, 1930, that I last saw him alive on May 31, 1930, and that death occurred, on the date stated above, at 5.07 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension, Myocardial
Insufficiency & failure.

(duration) 1 yrs. ... mos ... da.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ... yrs. ... mos. 14 da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Hedwig Koenig, M. D.

5/31/1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd.

DATE OF BURIAL June 1 1930

20 UNDERTAKER S. Levinson Bro

ADDRESS 1527 E Balto St.

Instructions very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 57653 HEALTH DEPARTMENT—CITY OF BALTIMORE

43 E 57653

CERTIFICATE OF DEATH

1-PLACE OF DEATH Jenkins Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 1000 Caton Ave ST. 25-72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Clarke

(a) RESIDENCE NO. Lansdowne ST., Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced, (write the word)~~
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of George L. Clarke

6 DATE OF BIRTH (month, day, and year) July 5th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) Ste. Mary's Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Washington Abell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Isabella Stone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Jenkins Memorial Hosp 1000 Caton Ave

Filed JN 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1927, to May 31, 1930, that I last saw h~~e~~r alive on May 30, 1930, and that death occurred, on the date stated above, at 1-30 P m. E.S.T.

The CAUSE OF DEATH* was as follows:

Carcinoma of upper lip (later involving most of face)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Ernest Spencer, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 6/3 1930

20 UNDERTAKER H. C. Cook

ADDRESS 1214 E Cold St

Now is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—350 Blks

Kilby 622 N. Ave

E 57654 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57654

CERTIFICATE OF DEATH.

74-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 N Brice St - 16 - 22 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Virginia Waskey

(a) RESIDENCE NO. 817 N. Brice ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer Waskey

6 DATE OF BIRTH (month, day, and year) Dec. 30 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. W. Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Bankard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr. Elmer Waskey (Address) 817 N. Brice St.

15 Filed ..... 19 .....

G. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30/30

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1930, to May 30, 1930, that I last saw him alive on May 30, 1930, and that death occurred, on the date stated above, at 1.35 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 da.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Gray, M. D.

5/31, 1930 (Address) 622 N. Kilby Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenlawn - Hearse under Jun 2 1930

DATE OF BURIAL

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

JUN 1 1930

Spec.—1-30—M. & T.—250 Blks.

E 57655 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57655

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 9-47 ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Green

(a) RESIDENCE NO. 3601 Greenmount Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Jan. 31, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ala.

PARENTS

10 NAME OF FATHER William Cullum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Jane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed JUN 1 - 1930 C. HAMPSON JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-30-30

17 I HEREBY CERTIFY, That I attended deceased from 5-3-30, 19..., to 5-30-30, 19...,

that I last saw her alive on 5-30-30, 19...,

and that death occurred, on the date stated above, at 5:05 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute.

Move than 1 yrs. mos ds. (duration)

CONTRIBUTORY (Secondary) Arteriosclerosis unknown - (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Podgett., M. D.

5-31, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 6/2, 1930

20 UNDERTAKER M. Wm. Cook

ADDRESS 1219 E. Pratt St

Instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 57656 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57656

CERTIFICATE OF DEATH.

48

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6111 Belair Rd ST. ..... WARD 47-43

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome P. Rambo

(a) RESIDENCE NO. 6111 Belair Rd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Mary A.

6 DATE OF BIRTH (month, day, and year) Jan 29th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Brokaw Bros

9 BIRTHPLACE (city or town) Kent Co (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Kent Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Shambo

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Unknown

14 Informant John H. Rambo

(Address) 2000 Harford Ave.

15 Filed JUN 1 1930, 19... C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30th 1930 4.05 P.M.

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1930, to May 31, 1930, that I last saw him alive on May 31, 1930 and that death occurred, on the date stated above, at 4.05 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

(duration) ..... yrs. 4 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Harry A. Long, Jr. M. D.

1930 (Address) 5631 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery — DATE OF BURIAL 6/2/1930

20 UNDERTAKER Wm Cook 1217 — ADDRESS St Paul St

Specific directions regarding the items are important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

E 57657

HEALTH DEPARTMENT—CITY OF BALTIMORE

29 E 57657

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No.) W. C. Balto Gen Hos St. (Ward) 28-603

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kenneth L. Sebo

(a) RESIDENCE NO. 5302 Morgan Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of NO

6 DATE OF BIRTH (month, day, and year) Aug 19-1916

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	13	9	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER W. Berkley Sebo

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Elsie Gardner

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant W. Berkley Sebo
(Address) 5302 Duncan

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains deseribed above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident fell out of tree

Returns, Fractured Femur, Radius & Ulna

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Fell out of tree

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Baltimore Maryland

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ..... M. D.

May 31 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	6/3 1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57658 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57658

CERTIFICATE OF DEATH

1—PLACE OF DEATH Children's Hospital School. REGISTERED NO. 84

CITY OF BALTIMORE: (No. 41st & Greenspring ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Stagg

(a) RESIDENCE NO. Snowhill, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. 19 How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 4, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Snowhill, Md.

PARENTS

10 NAME OF FATHER Robert Stagg, Sr.

11 BIRTHPLACE OF FATHER (city or town) Snowhill, (State or country) Md.

12 MAIDEN NAME OF MOTHER Lottie Jordy.

13 BIRTHPLACE OF MOTHER (city or town) Pine (State or country) Virginia.

14 Informant (Father) Robert Stagg. (Address) Snowhill, Md.

15 Filed June 1, 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to June 1, 1930, that I last saw him alive on June 1, 1930, and that death occurred, on the date stated above, at four a. m.

The CAUSE OF DEATH* was as follows:

Little's Disease

(duration) 5 yrs. 9 mos. 27 ds.

CONTRIBUTORY (Secondary) Craniotomy

(duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? Yes Date of May 14, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Raymond E. Lenhard, M. D.

19 (Address) 11 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Snow Hill, Md

DATE OF BURIAL 6/1 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Fayette St

1-30—M. & T.—100 B—50L

E 57659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57659

188-103

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 929 E Preston St. 10-14 (WARD)

2-FULL NAME John G Gehring

(a) RESIDENCE NO 929 E Preston St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a If married, widowed, or divorced
(or) wife of Mary A. Gehring

6 DATE OF BIRTH (month, day, and year) Jan 29-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of Industry, business, or establishment in which employed (or employer) Stone
(c) Name of employer cutter

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Andrew Gehring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Gruendel

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant Mrs Lena Gehring

(Address) 929 E Preston St

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck & knocked down by backing truck while walking along pavement

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Int Hemorrhage & Fract Rib (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Asquith nr Chase

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Crane M. D.
May 31, 1930 (Address) 2939 Mc Elderry Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL June 3 1930

20 UNDERTAKER Henry Koch & Sons Inc ADDRESS 1301 E Eager

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-30—M. & T.—250 Bks

E 57660 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57660

CERTIFICATE OF DEATH.

91-007

REGISTERED NO. 10-14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1221 N. Central St. WARD)

2-FULL NAME Barbara Phillmann

(a) RESIDENCE NO. 1221 N. Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 2 mos. 17 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of John A. Phillmann

6 DATE OF BIRTH (month, day, and year) March 14 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John A. Rosenberger

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs. Marie C. Bressler

(Address) 1221 N. Central ave.

Filed JUN 1 - 1930 19 C. HUDSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10th 30 to May 31st 30 19

that I last saw h alive on May 14th 19 30

and that death occurred, on the date stated above, at 7 45 a m.

The CAUSE OF DEATH* was as follows:

Uremic Intoxis

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Jones M. D.

May 31 19 30 (Address) 1400 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL June 4 19 30

20 UNDERTAKER Henry Hoeck Sons Inc

ADDRESS 1301 E Eutaw pl

ATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 57661

E 57661

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2124 Maryland Ave ST. 7-51 WARD)

2-FULL NAME John G. Baer

(a) RESIDENCE NO. 2124 Maryland Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? 65 yrs. ~ mos. ~ ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of the late or WIFE of Barbara Baer

6 DATE OF BIRTH (month, day, and year) Dec. 18 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	80	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant M. J. Fred. Baer

(Address) 824 E. 33rd St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1930

17

I HEREBY CERTIFY, That I attended deceased from Mar 10, 1930, to May 30, 1930, that I last saw him alive on May 29, 1930, and that death occurred, on the date stated above, at 2 30 A. m. (E.S.T.).

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, chr. myocarditis, chr. cholecystitis. Pontile thrombosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Respiratory paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clin. data

(Signed) Leo Schlenger M. D.

5/30/, 1930 (Address) 3034 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: June 2 1930

20 UNDERTAKER: Henry Hock Sons, Inc. — ADDRESS: 1301 E Eager St

N 1 1930 C. HARRISON JONES

Spec.—1-30—M. & T.—250 Blks

E 57662 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57662

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 13-59 ST. (WARD)

2-FULL NAME Baby Girl Mercy

(a) RESIDENCE NO. 2424 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 3 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or estsblishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Max Mercy

11 BIRTHPLACE OF FATHER (city or town) New York city
(State or country)

12 MAIDEN NAME OF MOTHER Myrtle Applefeld

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Hospital Records
(Address)

15 Filed 6/1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from 6-1, 1930, to 6-1, 1930,

that I last saw h[illegible] alive on 6-1, 1930,

and that death occurred, on the date stated above, at 5:19 m.

The CAUSE OF DEATH* was as follows:

Intrauterine asphyxia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

6/1, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL June 1 1930

20 UNDERTAKER Jack Lewis, 1439 — ADDRESS E Balto St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57663 ✓ E 57663

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1516 John St ST. 14-20 WARD)

2—FULL NAME Mary E. Perkinson

(a) RESIDENCE NO. 1516 John ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John P. Perkinson

6 DATE OF BIRTH (month, day, and year) Mch 3. 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 31

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Geo. H. Minner

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Susan McCarthy

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant John P. Perkinson Husband

(Address) 1516 John St

15 Filed ..... 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 - 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 19 30, to May 30, 19 30, that I last saw h W alive on May 30, 19 30 and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

acute Pneumonary Tuberculosis
(Phthisis Florida)
(duration) ..... yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Chas. F. A. Stevens, M. D.

5/31, 19 30 (Address) 2878 Stafford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery	April 2 1930
20 UNDERTAKER Margaret D. Flynn	ADDRESS 14 W Eager St.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 5766

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 57664

REGISTERED NO. 27-45

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3108 Baltimore Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate Farrington Clarke

(a) RESIDENCE NO. 3108 Baltimore Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. H. Clarke

6 DATE OF BIRTH (month, day, and year) Oct 22-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Wm H Davis

11 BIRTHPLACE OF FATHER (city or town) Wash (State or country)

12 MAIDEN NAME OF MOTHER Catherine Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Mary Smith

(Address) 3108 Baltimore Ave

15 Filed JUN 1 1930, 19 C. HUDSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31st 1930

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to May 31, 1930

that I last saw h alive on May 30, 1930

and that death occurred, on the date stated above, at 12 10 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Colon

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Elmer A Long M. D.

5/31, 1930 (Address) 3681 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery DATE OF BURIAL June 2nd 1930

20 UNDERTAKER Putnam & Poe ADDRESS 1723 W Lafayette Ave

Spec.—1-30—M. & T.—250 Bks.

E 57662 E 57665

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp. (ST.) 26-2 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Frederick

(a) RESIDENCE NO. 320 N. Bouldin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Wht	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 3-17-76

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Daniel Grady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hospital Record

15 Filed JUN 1 1930 C. HAMPSON JONES, M. D. Registrar By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-30-30

17 I HEREBY CERTIFY, That I attended deceased from 4-20, 1930, to 5-30, 1930, that I last saw h.w alive on 5-30, 1930, and that death occurred, on the date stated above, at 9 50 a. m.

The CAUSE OF DEATH* was as follows:

Renal Cholecystitis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Coronary embolus (duration) yrs. mos. 1 hr

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 4-24-30

Was there an autopsy? No

What test confirmed diagnosis? Operation Drainage of Gall Bladder

(Signed) L. H. Livingston, M. D.

5-31, 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart DATE OF BURIAL June 1st 1930

20 UNDERTAKER John J. Grey Son ADDRESS 1318 Light

Spec.—1-30—M. & T.—250 Blks.

E 57666 ✓ E 57666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — REGISTERED NO. _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No.) 3608 Elm Ave. ST., 13-52 WARD

2-FULL NAME William F. Lindsay

(a) RESIDENCE NO. 3608 Elm Ave. ST., 13 WARD _____ (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 81 yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia A. Lindsay

6 DATE OF BIRTH (month, day, and year) Dec. 27-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired 5 years

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Archibald Lindsay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E Boyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Julia A. Lindsay (Address) 3608 Elm Ave

15 Filed May 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31-1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1929 to May 31 1930, that I last saw h[illegible] alive on May 31 1930, and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Primary

(duration) ..... yrs. ..... mos ✓ ds.

CONTRIBUTORY (Secondary) Myocarditis - 3 yrs

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Clinical Physical

(Signed) I. J. Fuller, M. D.

, 19 (Address) 710 N Fare-Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL June 2 1930.

20 UNDERTAKER Horace H. Burgee — ADDRESS 3631 Hallo Road

Instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57667 E 57667 E 57667 90 E 57667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 8-17 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Cartlich

(a) RESIDENCE NO. 1225 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Harry [illegible]

6 DATE OF BIRTH (month, day, and year) [illegible] 17, 1844

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85 ~~86~~	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) O&T

(c) Name of employer

9 BIRTHPLACE (city or town) Hanover
(State or country) Pa.

PARENTS

10 NAME OF FATHER Unknown Jacob Wonderly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Phila Unknown Pa

12 MAIDEN NAME OF MOTHER Unknown Mary Spencer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Phila Unknown Pa

14 Informant Records of
(Address) Balto City Hosp.

15 Filed N 1 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-30-30

17 I HEREBY CERTIFY, That I attended deceased from 5-16-30, 19..., to 5-30-30, 19...,
that I last saw her alive on 5-30-30, 19...,
and that death occurred, on the date stated above, at 12:35 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute.
(duration) More than 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Histology exam.

(Signed) Paul Padget, M. D.
5-30, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns - Waverly

DATE OF BURIAL 6-2-30

20 UNDERTAKER Wendell E. Humphreys

ADDRESS 2416 E. Lafayette Ave

See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 57668

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

18 V E 57668

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Foot of Cross St. St.) 24-33 (Ward)

2-FULL NAME Saul Wiernik.

(a) RESIDENCE NO. 1818 William St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 10 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) July 19, 1909

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	21	10	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Simon Wiernik.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia.

12 MAIDEN NAME OF MOTHER Sarah L. Bowers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Harry Wiernik. (brother)
(Address) 859 S. 2nd St. Brooklyn N.Y.

15 Filed ... 19.. C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Missing May 24, 1930 Found May 30, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning, while in bathing.

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible], M. D.

6/1, 1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	6/1 1930
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57669

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57669

CERTIFICATE OF DEATH

11-002

REGISTERED NO. 27-45

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infy ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lois Becker

(a) RESIDENCE NO. 2907 Glenmore Ave ST., WARD Hamilton
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lydia Becker

6 DATE OF BIRTH (month, day, and year): Mar 29 - 1875

7 AGE: Years 55 | Months 2 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Office manager

(b) General nature of industry, business, or establishment in which employed (or employer): Hat Factory

(c) Name of employer: Hat-basket Co.

9 BIRTHPLACE (city or town) (State or country): Penn

PARENTS

10 NAME OF FATHER: Fred. Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Annie Rickel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lydia R. Becker
(Address): 2907 Glenmore Ave

15 Filed [illegible] 19[illegible] [illegible] Registrar

JUN 1 - 1930 C. HAWSON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1930, to May 29, 1930, that I last saw him alive on May 29, 1930, and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Generalized & localized peritonitis following ruptured duodenal ulcer

(duration) — yrs. — mos. 3½ ds.

CONTRIBUTORY (Secondary) duodenal ulcer (duration) — yrs. 6 mos. ? — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross findings

(Signed) Vernon H. Norwood, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem

DATE OF BURIAL: 6/2 1930

20 UNDERTAKER: J. J. Moran

ADDRESS 3000 E Baltimore

Sp— 2-29-28—L. F. S.—500 Bks.

E57670 HEALTH DEPARTMENT—CITY OF BALTIMORE E57670

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Aisquith ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James F. McCabe

(a) RESIDENCE NO. 1216 Aisquith ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose G. McCabe

6 DATE OF BIRTH (month, day, and year) Aug. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police

(b) General nature of industry, business, or establishment in which employed (or employer) Balto-Ind. 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER James McCabe

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Mary Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire

14 Informant Rose G. McCabe
(Address) 1216 Aisquith St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1930

17 I HEREBY CERTIFY, That I attended deceased from May ..., 19 20, to May 27th, 19 30

that I last saw h) alive on May 26th, 19 30

and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. O. Monro, M. D.

May 27, 19 30 (Address) 4900 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL June 2 1930

20 UNDERTAKER J. A. Moran ADDRESS 3000 E. Baltimore

Spec.—1-30—M. & T.—250 Blks.

E 5767 E 5767

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57671 E 57671

CERTIFICATE OF DEATH.

REGISTERED NO. 143

1-PLACE OF DEATH So. Balto Gen'l Hosp ST 25-31 WARD

CITY OF BALTIMORE: (No.

2-FULL NAME Pearl E. Revere

(a) RESIDENCE NO. 121 W. Ostend St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Lawson Revere

6 DATE OF BIRTH (month, day, and year) May 4/1903

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
27	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nora Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lawson Revere

(Address) 114 Burnett St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31/30

17 I HEREBY CERTIFY, That I attended deceased from 5/29, 1930, to 5/31, 1930, that I last saw her alive on 5/31, 1930, and that death occurred, on the date stated above, at 7:20 a.m.

The CAUSE OF DEATH* was as follows:

Pregnancy

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Myocardial failure (duration) yrs. mos. 2½ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of 5/29/30

Was there an autopsy? yes Tumor of head

What test confirmed diagnosis? clinical

(Signed) Francis O'Reilly M. D.

, 19 (Address) 1113 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk

DATE OF BURIAL June 2, 30

20 UNDERTAKER Phillips Herwig

ADDRESS 2016 Orleans St

C. HARRISON JONES

Registrar

JUN 1 1930

Spec.—1-30—M. & T.—250 Bks.

E 57672

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57672

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3415 Esther Place ST., 13-59 WARD

2-FULL NAME Margaret S. Balling

(a) RESIDENCE NO. 3415 Esther Place ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Balling

6 DATE OF BIRTH (month, day, and year) June 2 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frederick Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sophia Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John J. Balling
(Address) 3415 Esther Place

15 Filed ..... 19 ..... C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1930, to May 31, 1930, that I last saw h[illegible] alive on May 31, 1930, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Contusion Lung Intestines

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. H. Schleuder, M. D.

June 2, 1930 (Address) W. H. Schleuder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL June 2 1930

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Cuba and Av

(Last - Todd - [illegible])

Spec.—1-30—M. & T.—250 Bks.

E 57673 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 57673

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 27-43 St. (WARD))

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas M Cate

(a) RESIDENCE NO. 3023 Northern Pkwy ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Cate

6 DATE OF BIRTH (month, day, and year) Feb 19 1869

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tenn.

PARENTS

10 NAME OF FATHER Carr Cate

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn

12 MAIDEN NAME OF MOTHER Phy. Witt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn

14 Informant Hospital Record (Address)

Filed JUN 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/31/30

17 I HEREBY CERTIFY, That I attended deceased from 5-6, 1930, to 5-31, 1930, that I last saw him alive on 5-31, 1930, and that death occurred, on the date stated above, at 12¼ A m.

The CAUSE OF DEATH* was as follows:

Cellulitis leg

(duration) yrs. mos 25 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 5/19/30 Incision Drainage

Was there an autopsy? No

What test confirmed diagnosis? Clinical + oper.

(Signed) J Geyko, M. D.

5/31, 1930 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem DATE OF BURIAL June 2, 1930

20 UNDERTAKER Forest Lyon ADDRESS Balt. Md.

NOTE—It is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

237048
E 57674

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57674

146

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 4-3 WARD)

2-FULL NAME Thelma Januchowski

(a) RESIDENCE NO. 2725 Hudson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec-24-1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elevator Girl

(b) General nature of industry, business, or establishment in which employed (or employer) 0&6

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Januchowski

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Frances Berry

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19..... E. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30-1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to May 30, 1930, that I last saw her alive on May 30, 1930, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) ..... yrs. ..... mos 15 ds.

CONTRIBUTORY (Secondary) Placenta praevia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 17

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F F Snyder, M. D.

5-30, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem June 3-1930 DATE OF BURIAL

20 UNDERTAKER John M. Weber ADDRESS 401 E Chester St

Missing

#E57675

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57676

CERTIFICATE OF DEATH

× 129 ✓

E 57676

1—PLACE OF DEATH V. A. Marion Hosp. Balto Md.

REGISTERED NO. 12-51

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cecil Bingham

(a) RESIDENCE NO. West Point Va. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug 2 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
23	23	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor (Fireman)

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Chesapeake Steamship Co

9 BIRTHPLACE (city or town) ..... (State or country) Va

PARENTS

10 NAME OF FATHER Lee Bingham

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER Mannie Jackson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va.

14 Informant Hospital Records

(Address) V. A. Marion Hospital

15 Filed JUN 2 1930 H. A. [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1930

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1930 to June 1, 1930, that I last saw him alive on June 1 & 15, 1930 and that death occurred, on the date stated above, at 5-15 m.

The CAUSE OF DEATH* was as follows:

Nephritis Parenchymatous Chronic

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Va

Did an operation precede death? no Date of ✓

Was there an autopsy? no-

What test confirmed diagnosis? Clinical Laboratory

(Signed) J C Graves, M. D.

19 (Address) V A Marion Hosp. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Point Va	June 3 1930

20 UNDERTAKER E. Leroy Stiffler & Sons

ADDRESS 125 E. North Ave.

SEE INSTRUCTIONS ON BACK OF CERTIFICATE IF YOU

Spec.—2-29-24—L. F. S.—600 Bks.

Harry L. Black Jr

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002

E 57677

CERTIFICATE OF DEATH

E 57677

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4635 St Albans Way St. Homeland WARD 27-48

2—FULL NAME Harry L Black Jr

(a) RESIDENCE NO. 4635 St Albans Way WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. ~ mos. ~ ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Alberta M Black

6 DATE OF BIRTH (month, day, and year) Nov 24. 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumbing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer H. L. Black & Son

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry L Black

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Nettie Fox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Alberta M. Black

(Address) 4635 St Albans Way

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1930

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1930, to June 5, 1930, that I last saw him alive on June 5, 1930 and that death occurred, on the date stated above, at 5-4 m.

The CAUSE OF DEATH* was as follows:

Septic Sore Throat

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Clinical Exam

(Signed) C. B. Simon, M. D.

6-1-, 1930 (Address) 4936 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL JUN 3 1930

20 UNDERTAKER Robert S. Sittler

ADDRESS 2700 EDMONDSON AVE.

JUN 2 - 1930

Spec.—1-30—M. & T.—250 Blks

57678 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

179 E 57678

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Main Memorial ST., 354 WARD)

2-FULL NAME Ben Bronski

(a) RESIDENCE NO. 301 S Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal.	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4 1894

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	36		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Leon Bronski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Emma Doosh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant wife

(Address) 301 S Bond St

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 30

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to May 31, 1930, that I last saw him alive on May 31, 1930, and that death occurred, on the date stated above, at 11:15 A m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab. findings

(Signed) Nicholas Langwood, M. D.

, 19 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russian Independet	June 3, 1930
20 UNDERTAKER	ADDRESS
John Grebliauckas	423 S Paca St

Keep this certificate very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

Setting

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57679

CERTIFICATE OF DEATH.

50 E 57679

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. St. 11-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Worthington Setting

(a) RESIDENCE No. 227 W. Lafayette Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 14 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER C Boxley Setting

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Marie Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital records (Address)

15 Filed 2-1930 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to May 30, 1930, that I last saw him alive on May 30, 1930, and that death occurred, on the date stated above, at 7⁰⁰ P m. (STANDARD Time)

The CAUSE OF DEATH* was as follows:

Paralysis of the Rectum & sigmoid Flexure of entire intestinal tract.

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia acute

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Samuel McClanahan, M. D.

May 30, 1930 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem

DATE OF BURIAL June 2 1930

20 UNDERTAKER John O Mitchell & Son

ADDRESS 1900 Eastern Ave

Please fill very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57680 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57680

CERTIFICATE OF DEATH. 145-09

1-PLACE OF DEATH St Joseph Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 6 Caroline Ave STREET OR AVENUE) (WARD 10)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Miller

(a) RESIDENCE NO. 129 N Bernard Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Louis Miller

6 DATE OF BIRTH (month, day, and year) June 3, 1896

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
33	11	30 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER William Schramm

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Margaret Seifert

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Louis Miller

(Address) 129 N Bernard Ave

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-30-30

17 I HEREBY CERTIFY, That I attended deceased from 5-21-30, 19..... to 5-30-30, 19.....

that I last saw h[illegible] alive on 5-30-30, 19.....

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cardio - Renal disease - Lobar Pneumonia

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5-21-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) H B Lindsay, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schaefer's Cemetery DATE OF BURIAL June 3 1930

20 UNDERTAKER Wm. E. Muller & Son ADDRESS 2304 Jefferson St

FROM IS very important. See instructions on back of certificates. ...ENT OF OCCUPA-

Spec.—12-9-25—A Co.—200 Bks.

Fritz

HEALTH DEPARTMENT—CITY OF BALTIMORE

49

CERTIFICATE OF DEATH.

E 57681

REGISTERED NO. E 57681

1-PLACE OF DEATH

City of BALTIMORE: (No. 1835 N. Castel St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ludwig Fritz

(a) RESIDENCE NO. 1835 N. Castel St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Teresa Fritz

6 DATE OF BIRTH (month, day, and year): Aug 15 1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Steel

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Ottmar Fritz

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Martha Zeitner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Teresa Fritz

(Address): 1835 N. Castel St

15 Filed ....., 19..... JAMES H. JOYCE, M. D. Registrar

12-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1930: May 31

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1920, to May 31, 1930, that I last saw him alive on May 31, 1930, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Recurd carcinomatosis - + Ray - Stomach - Neoplasm originally in Left lung - ? carcinoma of lung - primary.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary): arter. & clerosis - chr. nephritis -

(duration) 2 yrs. mos. ds.

18 Where was disease contracted: —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? + Ray - urine - ca —

(Signed) Louis F. Kuhlmann, M. D.

, 19 (Address) 722 N. Kenwood Ave —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial: Jun 3 1930

20 UNDERTAKER: Frank A. Fink ADDRESS: 916 N. Gay St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57682

HEALTH DEPARTMENT—CITY OF BALTIMORE

164

E 57682

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 944 N. Balto ST. 18-76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Opper Sr.

(a) RESIDENCE NO. 944 N Balto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Wid

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Bertha Opper

6 DATE OF BIRTH (month, day, and year) Dec. 5, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	90	5	6	

8 OCCUPATION OF DECEDENT

(a) Trade, profession or particular kind of work Shoe Maker (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER John Opper

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Mary Koester

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant John Opper Jr

(Address) 944 N. Balto

Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31/30

17 I HEREBY CERTIFY, That I attended deceased from May 29, 19..., to May 31, 19 30,

that I last saw h... alive on May 31, 19 30

and that death occurred, on the date stated above, at 7 15 m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) ...yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F Howard, M. D.

June 1, 19 30 (Address) 939 N. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL June 3 1930

20 UNDERTAKER F. Vernon Leehner

ADDRESS 1532 Hollins St

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

215 65-0 57683

HEALTH DEPARTMENT—CITY OF BALTIMORE

71-001 E 57683

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 12-51 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Winemiller

(a) RESIDENCE NO. 124 W. 25 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	—

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 12-1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Erwin Winemiller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Winemiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31-1930

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 31, 1930, that I last saw him alive on May 31, 1930, and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Streptococcus meningitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? here

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) J. R. Buckford, M. D.

6/1, 1930 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leland Balto Co

DATE OF BURIAL June 2 1930

20 UNDERTAKER Brownell & Son

ADDRESS 3615 Eastern

IMPORTANT: See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57684 ✓ 119 E 57684

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. 13-57 ST., WARD)

2-FULL NAME Ida May Bowen

(a) RESIDENCE NO. 1114 W 36th ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): March 2, 1913

7 AGE	Years	Months	Days	If LESS than 1 day, .. hrs. or .. min.
	17	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md.

PARENTS

10 NAME OF FATHER: Benjamin Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Alice M. Eldridge

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md.

14 Informant: Alice M. Bowen
(Address) 1114 W 36th St

Filed JUN 2 - 1930 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-10 .1930. to 5-31 .1930.

that I last saw her alive on 5-31 .1930.,

and that death occurred, on the date stated above, at 9-30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary): Peritonitis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5-31-30

Was there an autopsy? no (Laparotomy)

What test confirmed diagnosis? Operation

(Signed) Emmett Spencer Jr, M. D.

.19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn | DATE OF BURIAL: June 3 1930

UNDERTAKER: Rhinowitch or | ADDRESS: 3615 Putnam ave

DEATH CERTIFICATES should be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 57685

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57685

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 809 Wellington St. 13-52 (WARD)

2-FULL NAME Sarah Anna Gullicon.

(a) RESIDENCE NO. 809 Wellington St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Enoch Gullicon.

6 DATE OF BIRTH (month, day, and year) June 12 1842

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
87	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Wm Lilly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Joseph B. Mitchell

(Address) 809 Wellington St

15 Filed 1930 E. HANDY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 30

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1928, to June 1, 1930, that I last saw h[illegible] alive on June 1, 1930, and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial degen & Chronic interstitial nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

6/7, 1930 (Address) 846 W 36th St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cemetery

DATE OF BURIAL June 3 1930

20 UNDERTAKER [illegible]

ADDRESS 360 Chestnut

Please write very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2372 E 57686 E 57686 X 49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St. 16-22 Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeannette Champion

(a) RESIDENCE NO. 922 N Bruckes ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	—

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	21	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER James Eldin

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER May Champion

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 6-2-1930 19 C. HUDSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-29-30

17 I HEREBY CERTIFY, That I attended deceased from 5-23-, 19 30, to 5-29-, 19 30,
that I last saw h alive on 5-29-, 19 30,
and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Brain tumor - Malignant

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-28-30

Was there an autopsy? Yes Gross and brain

What test confirmed diagnosis? X-ray

(Signed) C. H. Frazier, M. D.

5/31/30 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 6/1 1930

UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pressman St

FROM A VERY IMPORTANT. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57687

CERTIFICATE OF DEATH.

129 E 57687

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2516 Federal st ST., 8 17 WARD)

2-FULL NAME Joseph B. Maguire sr.

(a) RESIDENCE No. 2516 Federal ST., E. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of ~~or~~ WIFE of Katherine Maguire

6 DATE OF BIRTH (month, day, and year) Dec 25-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector

(b) General nature of industry, business, or establishment in which employed (or employer) Dept Store

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country) ~~Ireland~~

PARENTS

10 NAME OF FATHER James Maguire

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Katherine Maguire.
(Address) 2516 Federal St Wife

15 Filed ..... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31-1930

17 I HEREBY CERTIFY, That I attended deceased from 3-17 1930 to 5-31 1930

that I last saw h... alive on 5-30 1930

and that death occurred, on the date stated above, at 6 45 A.M. m.

The CAUSE OF DEATH* was as follows:

a Chronic nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	June 3 1930
20 UNDERTAKER	ADDRESS
Lilly Zeiler Inc.	403 S. Wolfe

Note—Very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57688 90 E 57688

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2109 E. Federal ST., 8 16 WARD)

2-FULL NAME Charles Knoepp

(a) RESIDENCE NO. 2109 E. Federal ST., 8 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Annie D. Knoepp.

6 DATE OF BIRTH (month, day, and year) Feb. 23rd 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Christian Knoepp

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Annie D. Knoepp (Wife)
(Address) 2109 E. Federal St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29th/30

17 I HEREBY CERTIFY, That I attended deceased from April 14- 1928 to May 29- 1930, that I last saw him alive on May 27- 1930, and that death occurred, on the date stated above, at 4:55 p.m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(duration) 4 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) — yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Zenby, M. D.

5/31/1930 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL June 2nd 1930

20 UNDERTAKER Lilly & Zeller Inc. — ADDRESS 403 S. Wolfe St

Please read very important. See instructions on back of certificates.

29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57689

CERTIFICATE OF DEATH

129 ✓ E 57689

LACE OF DEATH

REGISTERED NO.

F BALTIMORE: (No. 719 Linard ST. 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

LL. NAME Anna Hanna

SIDENCE NO. 719 Linard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

sidence in city or town where death occurred 57 yrs. 1 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

RSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

widowed, or divorced
D of
E of George S Hanna

ATE OF BIRTH (month, day, and year) April 23 1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Winkler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs George S Hanna

(Address) 719 Linard St

15 Filed 2 1930 19 RPK, Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1930

17

I HEREBY CERTIFY, That I attended deceased from 1926 to May 31 1930

that I last saw her alive on May 31 1930

and that death occurred, on the date stated above, at 7 45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - Arteriosclerosis hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Sol. Wessig, M. D.

6/2 1930 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: 6/4 1930

20 UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57690

CERTIFICATE OF DEATH

198 E 57690

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 18-W Ward)

2-FULL NAME Neal Payne

(a) RESIDENCE NO. 221 Cove Alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) S.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Florence Payne
(Address) 221 Cove St.

15 Filed NOV 2 1930 16 C. HAMPSON JONES, M. D. Registrar

Rigt.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to stab wound of neck. Homicide. Stabbed w Knife.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene Feltz M. D.

6/2. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn D.C.	June 1 1930
20 UNDERTAKER	ADDRESS
Samuel F. Hensley	1700 Bolton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57691

CERTIFICATE OF DEATH.

90 E 57691

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Eutaw Place H. ST., 70 WARD)

2-FULL NAME Mary Ellen Carroll

(a) RESIDENCE NO. 1604 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Carroll

6 DATE OF BIRTH (month, day, and year) Dec 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary E. Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Thomas J. Carroll

(Address) 1604 Eutaw Place

15 Filed JUN 2 1930 Per RHH, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 1, 1930.

that I last saw h.. alive on June 1, 1930.,

and that death occurred, on the date stated above, at 930 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H B Mellan, M. D.

, 19 (Address) 31 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loud Cathedral — DATE OF BURIAL June 2, 1930

20 UNDERTAKER Wm J Pickner & Sons — ADDRESS Mount Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57692

CERTIFICATE OF DEATH.

90 E 57692

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 N. Bentalou St. 16-68 WARD)

2-FULL NAME Irene Catherine Reeder

(a) RESIDENCE No. 1222 N. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 17, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Alphonse Reeder

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Allie Muse Reeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mr. Leonard Reeder

(Address) 1222 N. Bentalou St.

15 Filed JUN 2 - 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-31 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to May 31, 1930, that I last saw h[illegible] alive on May 31, 1930, and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis Signs & Symptoms

(Signed) [signature] M. D.

6/1, 1930 (Address) 511 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL June 1930

UNDERTAKER Wm. Fleckner Sons

ADDRESS North & Pa

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. PHYSICIANS should state that it may be properly classified.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

37-001

E 57693

CERTIFICATE OF DEATH

REGISTERED NO.

E 57693

1-PLACE OF DEATH

City of BALTIMORE: (No. 1400 Gorsuch Ave St. 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald M. Kehs.

(a) RESIDENCE NO. 1400 Gorsuch Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June -26- 1928.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	1	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Winfield M. Kehs.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth H. Cortez

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Winfield M. Kehs.

(Address) 1400 Gorsuch Ave.

15 Filed ... 19... C. HA... KELLY, M... Registrar

JUN 2 - 1930 By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to June 1, 1930,

that I last saw him alive on May 31, 1930,

and that death occurred, on the date stated above, at 3.10 A.m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) ... yrs. mos. 10 ds.

18 Where was disease contracted Contact with baby

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Fred. J. Zimmerman M. D.

June, 1930 (Address) 2458 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — Date of Burial June 3- 1930.

20 UNDERTAKER Charles J. Schwab. — ADDRESS 505 N. Monroe St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57694 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57694

90

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 636 Perkins Ave. ST., WARD)

2-FULL NAME Anna King

(a) RESIDENCE No. 636 Perkins Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59.	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 37
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS
10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md
12 MAIDEN NAME OF MOTHER Stephenson
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Henrietta Mason.
(Address) 636 Perkins ave

Filed 6-2 1930 G. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-31-30

17 I HEREBY CERTIFY, That I attended deceased from 3/10 19 to 5-27 1930,
that I last saw h[illegible] alive on 5/27 1930,
and that death occurred, on the date stated above, at 1 30 a. m.
The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) yrs. 1 mos ds.
CONTRIBUTORY (Secondary) Chronic myocarditis
(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) C. G. Hamilton, M. D.
5/31 19 30 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem
DATE OF BURIAL 6-2 1930
20 UNDERTAKER Dan'l Foster
ADDRESS 916 69

Be sure every item is complete. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57695

CERTIFICATE OF DEATH.

90

E 57695

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 N. Carlton ST. 18-26 WARD)

2-FULL NAME Rosie B Scott

(a) RESIDENCE NO. 119 N Carlton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Morris Scott

6 DATE OF BIRTH (month, day, and year): Jan 1883

7 AGE: Years 47 | Months 5 | Days - | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Richard Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Ford

(Address): 119 N Carlton St

15 Filed 2 1930, 19 Per C. THOMPSON JONES, JR. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to May 30, 1930,

that I last saw her alive on May 30, 1930

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Valvulitis

(Chronic)

(duration) ~~yrs.~~ mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. S. Howell M. D.

6/1 1930 (Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 6/2 1930

20 UNDERTAKER: Emanuel Bendix — ADDRESS: 78 Biddle

IMPORTANT. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 57696

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57696

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Infirmary, 6-9 St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Smith

(a) RESIDENCE NO. 2611 Grove Ave. Richmond, Va St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 30, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, 10 hrs. or 25 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER James Arthur Smith, Jr.

11 BIRTHPLACE OF FATHER (city or town) Birmingham, (State or country) Alabama

12 MAIDEN NAME OF MOTHER Mary Frances Davenport

13 BIRTHPLACE OF MOTHER (city or town) Chattanooga, (State or country) Tennessee

14 Informant

(Address)

15 Filed ... 19 ... C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to May 31, 1930, that I last saw her alive on May 31, 1930, and that death occurred, on the date stated above, at 6:25 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity, child seven months of age.

(duration) yrs. (7) mos ds.

CONTRIBUTORY (Secondary) Asphyxia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Erwin B. Wallace, M. D.

, 19 (Address) Church Home & Infir.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Church Home & Infirmary

DATE OF BURIAL MAY 31 1930

UNDERTAKER Commissioner Health.

ADDRESS

FROM IF VERY important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57697

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 57697

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST., WARD 27-42

2-FULL NAME Mrs. Ruth Trabert

(a) RESIDENCE NO. 6205 Fairdale Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Geo J Trabert

6 DATE OF BIRTH (month, day, and year) July 15-1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Michael Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER C. Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Geo J Trabert
(Address) 6205 Fairdale Ave

15 Filed ..... 19 .....

C. HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/31/30

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to May 31, 1930, that I last saw her alive on May 31, 1930, and that death occurred, on the date stated above, at 3. P m.

The CAUSE OF DEATH* was as follows:

Typhus Fever

(duration) ..... yrs. ..... mos 21 ds.

CONTRIBUTORY (Secondary) toxemia

(duration) ✓ yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 6205 Fairdale Ave.

Did an operation precede death? No Date of .....

Was there an autopsy? Partial

What test confirmed diagnosis? Agglutination test

(Signed) M. C. Hendley, M. D.

, 19 (Address) St. Jos. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rood - June 3

DATE OF BURIAL 6-30 19

UNDERTAKER Jas J Newsom

ADDRESS W Lexington

Please write very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57698 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57698

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Baltimore City Hosp ST 10-14 WARD)

2-FULL NAME Wm. Anderson

(a) RESIDENCE No. 809 Unity ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-24-69

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Stephen Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address)

15 Filed 6-2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-1-30

17 I HEREBY CERTIFY, That I attended deceased from 5-13, 1930, to 6-1, 1930, that I last saw h[illegible] alive on 6-1, 1930, and that death occurred, on the date stated above, at 4⁰⁰ P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma Stomach

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. W. Crumpton, M. D.

6-2, 1930 (Address) Balto City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery — DATE OF BURIAL June 4 1930

20 UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans st

See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57699

CERTIFICATE OF DEATH

57 E 57699

1—PLACE OF DEATH

REGISTERED NO. 19-28

CITY OF BALTIMORE: (No. 418 S. Strieker ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George W. Bentz

(a) RESIDENCE NO. 418 S. Strieker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie Harris Bentz

6 DATE OF BIRTH (month, day, and year) Dec 2 - 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	5	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired B & O R R

(c) Name of employer Westminster Md

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Gertrude Du Brittons

(Address) 418 S Strieker St

15 Filed 2 - 1930, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 - 1930

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1930, to June 1, 1930, that I last saw alive on May 31, 1930 and that death occurred, on the date stated above, at 1145 P m.

The CAUSE OF DEATH* was as follows:

Uraemia Sclerosis Diabetes Mellitus
Broncho Pneumonia
Diabetic coma

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis

(Signed) Thos F. Stevens, M. D.

6/2, 1930 (Address) 2515 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pipe Creek Cem Westminster Md

DATE OF BURIAL 6/4/30

20 UNDERTAKER Harry A. Witzke

ADDRESS 710 Edmondson Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

(Le Doyen)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57700

CERTIFICATE OF DEATH

129 E 57700

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-17 WARD)

2—FULL NAME John La Doyen

(a) RESIDENCE NO. Preston & Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John La Doyen

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Eliz. Wasa

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston & Valley St

15 Filed ... 19 ... Registrar

2 - 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from 5/15, 1930, to 6/1, 1930, that I last saw h alive on 5/31, 1930 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic Nephritis
Uremia (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Bernstein M. D.

6 Jr. 1930 (Address) 1216 E Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters

DATE OF BURIAL June 3 1930

20 UNDERTAKER Rita Wiedefeld

ADDRESS 1st Gruss

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57701

CERTIFICATE OF DEATH

100-002

E 57701

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1102 E Coatt St., 3-5 Ward)

2-FULL NAME Benj Gibson

(a) RESIDENCE NO. 1102 E Coatt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): May 26 1930

7 AGE — Years | Months | Days: 6 days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md

PARENTS

10 NAME OF FATHER: John B Gibson

11 BIRTHPLACE OF FATHER (city or town): Baltimore
(State or country): Md

12 MAIDEN NAME OF MOTHER: Senna M Parks

13 BIRTHPLACE OF MOTHER (city or town): Somerset County
(State or country)

14 Informant: John B Gibson
(Address): 1102 E. Coatt St

15 Filed 1930 C. H. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Bronchitis

(duration) hrs. mos. 1 day

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) Chas O Gladden, M. D.

1 19 (Address) 1432 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lahmans Cem — DATE OF BURIAL: June 2 1930

20 UNDERTAKER: Kendall & Lippel — ADDRESS: 3008 Eden

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57702

CERTIFICATE OF DEATH.

16 E 57702

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 6725 Roberts Pl ST., 26-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Reckenberger

(a) RESIDENCE NO. 6725 Roberts Pl ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): May 30-30

7 AGE: Years | Months | Days 1 | If LESS than 1 day, hrs. or min. 3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John H. Reckenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Marie E. Bruns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1930

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to June 1, 1930, that I last saw h— alive on June 1, 1930, and that death occurred, on the date stated above, at 7:36 P. M.

The CAUSE OF DEATH* was as follows:

6½ months

Premature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine, M. D.

June 2, 1930 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

JUN 2 - 1930

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57703

CERTIFICATE OF DEATH

90 E 57703

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1334 N. Bond ST. 817 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Fazzetta

(a) RESIDENCE NO. 1384 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 10/15/1909

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) 604

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Gennaro Fazzetta

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Josephine Fazzetta

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Gennaro Fazzetta

(Address) 1334 N Bond Street

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31/30

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1930, to May 31, 1930

that I last saw him alive on May 31, 1930

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Thrombosis

(duration) yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

Mitral Stenosis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mary J Ruth M. D.

(Address) 1735 Hanford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 6/3 1930

20 UNDERTAKER Mrs Mary J Ruth — ADDRESS 1735 Hanford Ave

Spec.—1-30—M. & T.—250 Blks

Dr Green — Maria Mildred Tyson

Harford & Evergreen

E 57704 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57704

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 W. Lanvale St., 39-40 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie B. Tyson

(a) RESIDENCE NO. 3146 Elmora Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

3 3:30 P.M.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Grafton S.

6 DATE OF BIRTH (month, day and year): June 23rd 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Grafton Bowers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Susie E. Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Graf Bowers

(Address) 310 W Lanvale

15 Filed 19 ACH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 18 1929 to June 1 1930

that I last saw h.. alive on May 30 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

about One year

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of the Liver

(duration) about One year

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.

6/1/30 19 (Address) 5543 Harford Rd. Hamilton Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, REMOVAL: Druid Ridge

DATE OF BURIAL: 6/4/ 1930

20 UNDERTAKER: Wm Cook 1217

ADDRESS: St Paul st

Store in very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 57705 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57705

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital ST. 12-49 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Getrude E. Lynch

(a) RESIDENCE NO. 220 Chauncy Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of John R Lynch

6 DATE OF BIRTH (month, day, and year) May 28th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Ernest Lehrieder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Hospital Records

(Address) Ross & Lottle 1002 Annapolis Blvd

15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd 1930

17

I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to June 2, 1930, that I last saw her alive on June 2, 1930, and that death occurred, on the date stated above, at 6.33 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Hypertension

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. 1-2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis W Gluck, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross (Harford Rd)

DATE OF BURIAL 6/4/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Please write very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 57706

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57706

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 414 E. 28th St. St. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Theresa A. Jones

(a) Residence No. 414 E 28th St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Thos O Jones

6-DATE OF BIRTH (month, day and year) 3/14/1882

7-AGE. 48 yrs. 2 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House wife

(b) General nature of Industry, business, or establishment in which employed (or employer). At Home

(c) Name of employer. Self

9-BIRTHPLACE (city or town) (State or Country). Miss.

PARENTS.

10-NAME OF FATHER. Enoc T. Hodges

11-BIRTHPLACE OF FATHER (city or town) (State or Country). West Va.

12-MAIDEN NAME OF MOTHER. Octavia Boggs

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ga.

14- (Informant) John H. Jones

(Address) 414 E. 28th St

15- Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 31. 1930

17- I HEREBY CERTIFY, That I attended deceased from ....., 19.15., to May 31, 1930.., that I last saw h. alive on May 29, 1930., and that death occurred, on the date stated above, at 8.05 m.

The CAUSE OF DEATH* was as follows: Carcinoma of Uterus

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Carcinomatosis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Geo. M. Steele, M. D.

6/2, 1930 (Address) 435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid's Central Cemetery Md

DATE OF BURIAL. 6/3/, 1930

20-UNDERTAKER. Wm Cook

ADDRESS 1217 St Paul St

Instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57707 ✓ 48 E 57707

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (NO. 1000 Caton Ave. ST. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank R. Schaefer

(a) RESIDENCE NO. 1422 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth L. Schafer

6 DATE OF BIRTH (month, day, and year) Dec 24—1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police

(b) General nature of industry, business, or establishment in which employed (or employer) 1861

(c) Name of employer Balto Police Dept.

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER J. F. Schaefer

11 BIRTHPLACE OF FATHER (city or town) Balto, Md (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Jenkins Memorial Hosp. (Address) 1000 Caton Avenue

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from 12-27, 1929, to 6-2, 1930, that I last saw h[illegible] live on 6-2, 1930, and that death occurred, on the date stated above, at 10^00 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of face

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brown, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's New Govans — DATE OF BURIAL 6/4 1930

20 UNDERTAKER Chas P. Gruss & Son — ADDRESS 1181 W. Mt Royal ave

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57708

CERTIFICATE OF DEATH

164 E 57708

1—PLACE OF DEATH

REGISTERED NO. 12-50

CITY OF BALTIMORE: (No. 313 E. 29th. St. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret H. McCabe.

(a) RESIDENCE NO. 313 E. 29th. St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Micheal F. McCabe

6 DATE OF BIRTH (month, day, and year) January 9th. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Charles Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Ann Williamson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mrs. Helen V. Evans

(Address) 313 E. 29th. St.

15 Filed 6-2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st. 1930

17 I HEREBY CERTIFY, That I attended deceased from 7/1/30, 19..., to 6/1/30, 19..., that I last saw her alive on 5/31/30, 19..., and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs...mos...ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Sudders, M. D.

6/2/30 19 (Address) 321 - E - 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Gabriel's Cem, Baltimore Co. Md.

DATE OF BURIAL 6/3 1930

UNDERTAKER Chas. E. Evans & Son ADDRESS 1184 W. Mt. Royal Ave

Cor.—10-10-29—A Co.—100 Bks.

E 57709

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

168

E 57709

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2817 W. La Fayette St.) 16-68 (Ward)

2-FULL NAME Wm E. Blankney.

(a) RESIDENCE NO. 2817 W. La Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie

6 DATE OF BIRTH (month, day, and year): May 27 1867

7 AGE: Years 63 | Months | Days 9 8 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John W. Blankney

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Annie Stahl

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Nellie Blankney
(Address) 2817 W La Fayette

15 Filed 1930 C. HAMPSON JONES, Registrar. M. D.

"or" RRB

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Suicide death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Strangulation by hanging
(duration) ..... yrs. Instant ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Harry Fleck M. D.
(Address) June 7 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wesley Cemetery — DATE OF BURIAL: June 4 1930

20 UNDERTAKER: Bernard G Funk — ADDRESS: 784 Washington Blvd.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 57710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 57710

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1326 Mount St., 15-22 WARD) 38

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Burke

(a) RESIDENCE NO. 134 Mount St WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 25. 1890

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER David Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Sarah Parran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Maggie Commodore

(Address) 1326 N. mount St

Filed 2 1930, 19 — Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/12, 1930, to 5/30, 1930, that I last saw h alive on 5/30, 1930 and that death occurred, on the date stated above, at 6 45 p m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

~~Endocarditis~~

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann (+)

(Signed) Chas Abbott, M. D.

5/31, 1930 (Address) 213 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 6/3 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

IMPORTANT See instructions on back of certificates. Exact statement of OCCUPATION is very important

Spec.—1-12-23—M&T—500 Blks.

E 57711

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 57711

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1430 Division St. 44-70 (WARD)

2-FULL NAME James D. Curtis

(a) RESIDENCE NO. 1430 Division ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Curtis

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE Years 63 Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

040

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophia Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Maggie Carey

(Address) 1430 Division St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to May 31, 1930, that I last saw him alive on May 31, 1930, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arteriosclerosis

(duration) Arteriosclerosis yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Ordinary Symptoms

(Signed) Roland Curtis, M. D.

June 2 1930 (Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL 6/3 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1308 Pennsylvania Ave

EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

2 - 1930 THOMPSON JONES, M.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57712

CERTIFICATE OF DEATH

166 E 57712

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 670 Ward)

2-FULL NAME Raymond H. Campbell

(a) RESIDENCE NO. 17 N. Port St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Campbell

6 DATE OF BIRTH (month, day, and year) Oct 23/1891

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38	7	10	8

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Welder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

886

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Hugh R. Campbell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Florence Crow

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

14 Informant Margaret Campbell
(Address) 17 N. Port St

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

2 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1/30

17 I HEREBY CERTIFY, That I took charge of the remains deseribed above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidenee obtained by said (Inquest, autopsy or inquiry) find that said deceased eame to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury Poisoning
Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes at Hopkins

What test confirmed diagnosis?

(Signed) J. C. Hall, M. D.

6/2/30 (Address) 508 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cem.

DATE OF BURIAL June 3 1930

20 UNDERTAKER Lilly & Gilcreine

ADDRESS 403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57713

CERTIFICATE OF DEATH

51 E 57713

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Gospital St. 8-11 Ward)

2-FULL NAME Albert C. Davis

(a) RESIDENCE NO. 1223 N. Ellwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Nellie V. Davis

6 DATE OF BIRTH (month, day, and year) Sept 6/1900

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	23	9	25 20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chemist
(b) General nature of industry, business, or establishment in which employed (or employer) 526
(c) Name of employer Sparrows Pt.

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Nellie V. Davis
(Address) 1223 N. Ellwood Ave

15 Filed ..... 19.. C. HAMPSON JONES, M. D.
Registrar

6-2-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1/30 1892

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Endocarditis

..... (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) History of Rheumatism

..... (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

6/2/30 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Mem.	June 4 1930
20 UNDERTAKER Lilly & Zeiler inc	ADDRESS 403 S. Wolfe St.

Spec.—1-30—M. & T.—250 Bks

E 57714 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57714

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St. 14-20 WARD)

REGISTERED NO. 65

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Hicks

(a) RESIDENCE NO. 1434 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5 If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Hicks

6 DATE OF BIRTH (month, day, and year) Oct. 12-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Perry C. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Christie Bennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas. E. Hicks Jr.

(Address) 1434 McCulloh St

15 Filed 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-31-30

17

I HEREBY CERTIFY, That I attended deceased from April 19, 1930, to May 31, 1930,

that I last saw h[illegible] alive on May 31, 1930,

and that death occurred, on the date stated above, at 9 30 m.

The CAUSE OF DEATH* was as follows:

Myelogenous Leukemia

(duration) about yrs. 2½ mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Carroll M St Clair, M.D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 6/3/1930

20 UNDERTAKER Spencer A Brown

ADDRESS 1631 Druid

624

Important: See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 57715

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001
100. E 57715

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 8-40 (Ward)

2-FULL NAME Joseph E. lober

(a) RESIDENCE NO. 3136 Ravenswood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10/30

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	4	22 24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(r) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Joseph R. Lober

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Rose Kelly

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Joseph R. Lober
(Address) 3136 Ravenswood Av

15 Filed 6-3-1930 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Hall, M. D.

6/2/30 (Address) 308 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	6/4/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57716

CERTIFICATE OF DEATH.

E 57716

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1409 Cario St. ST. 70-27 WARD)

2-FULL NAME Florence Smith

(a) RESIDENCE NO. 1409 Cario St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Negro	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank Smith

6 DATE OF BIRTH (month, day, and year) Jan. 21st. 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	33	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Emory Jennings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Furnace Branch Md.

12 MAIDEN NAME OF MOTHER Maria Queen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A.A. County Md.

14 Informant Rosetta Reed
(Address) 329 S. Fremount

Filed JUN 3 1930 C. HAMPTON JONES, M. D. Register

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31. 1930

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1930, to May 31, 1930
that I last saw her alive on May 29th. 1930
and that death occurred, on the date stated above, at 2;35 a.m.

The CAUSE OF DEATH* was as follows:

Menningitis of unknown origin

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery DATE OF BURIAL June 3, 1930

20 UNDERTAKER Mrs. Kate R. Williams ADDRESS 3224 Schroeder St

TION is very important. See instructions on back of certificates.

Spec.—3-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 57717

CERTIFICATE OF DEATH.

90 E 57717

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Linden Ave 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Cottman

(a) RESIDENCE NO. 922 Linden Ave E. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Cottman

6 DATE OF BIRTH (month, day, and year) April 7, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Dover Md.

PARENTS

10 NAME OF FATHER Ellen Cottman

11 BIRTHPLACE OF FATHER (city or town) Prince Anne (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Emma Cottman (Address) 922 Linden Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-30- 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-25-, 1930, to 5-30-, 1930, that I last saw him alive on 5-30-, 1930 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvulitis.

unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. H. Teagarden, M. D.

5-31, 1930 (Address) 611 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	June 3, 1930
20 UNDERTAKER	ADDRESS 3320
Mrs Katie R. Williams	Schroeder St

THIS is very important See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57718 | CERTIFICATE OF DEATH | 31 ✓ E 57718

1—PLACE OF DEATH — REGISTERED NO. 20-79

CITY OF BALTIMORE: (No. 118 Morley ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles W Whalen

(a) RESIDENCE NO. 118 Morley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Whalen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Casserly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Wm Whalen

(Address) 118 Morley St

15 Filed ..... 19 ..... C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2/32

17 I HEREBY CERTIFY, That I attended deceased from May 15 1932 to June 2 1932

that I last saw h[illegible] alive on June 1 1932

and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Ca Pulmonary

Pleurisy

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray

(Signed) W. A Buell, M. D.

6/2, 1932 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	6/3 '32
20 UNDERTAKER Geo A Tinsley Fulton	ADDRESS E Fayette

Spec.—1-30—M. & T.—350 Blks.

2E 57719 HEALTH DEPARTMENT—CITY OF BALTIMORE 16-002 E 57719

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 3-4 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Marks

(a) RESIDENCE NO. 2325 Bond ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 17 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md -
(State or country)

PARENTS

10 NAME OF FATHER Anthony Marks

11 BIRTHPLACE OF FATHER (city or town) Md -
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Myers

13 BIRTHPLACE OF MOTHER (city or town) Md -
(State or country)

14 Informant Records -
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-1-1930

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1930, to June 1, 1930, that I last saw h.er alive on June 1, 1930, and that death occurred, on the date stated above, at 9 26 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery -

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood cult.

(Signed) J. W. Bickford, M. D.

6/2, 1930 (Address) JHH.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	June 4 1930
20 UNDERTAKER	ADDRESS
M. M. G. Deppe Inc	37 S Arnold

IMPORTANT: See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57720

E 57720

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH Home

CITY OF BALTIMORE: (No. 1150 Washington Blvd ST., 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr John Kratzmeier

(a) RESIDENCE NO. 1150 Washington Blvd ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? [illegible] yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Schraft.

6 DATE OF BIRTH (month, day, and year) Jan 16 - 1808

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Built Cabinets

(c) Name of employer M. Pimlott Co.

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER August Kratzmeier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Kratzmeier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Bertha Kratzmeier

(Address) 1150 Washington Blvd.

15 Filed 3-1930 C. HANSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 - 1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to June 4, 1930, that I last saw him alive on May 30, 1930 and that death occurred, on the date stated above, at 5 06 m.

The CAUSE OF DEATH* was as follows:

Primal Carcinamatosis Abdominal

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) Days 2 yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W Warren Worley, M. D.

, 19 (Address) 910 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL June 4th 1930

20 UNDERTAKER Chas. W. Dill.

ADDRESS 3189 Frederick Ave.

Spec.—1-30—M. & T.—250 Blks.

E 57721 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57721

100

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 Weber St. St. 24-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Curtis M. Smith

(a) RESIDENCE NO. 118 Weber ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29-192[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Foard E. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna E. Konvalinka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Foard E. Smith (Address) 118 Weber St.

15 Filed 3-1930 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1-1930

17 I HEREBY CERTIFY, That I attended deceased from May 31- 1930, to June 1- 1930, that I last saw h[illegible] alive on June 1- 1930, and that death occurred, on the date stated above, at 12.45 [illegible] m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) Amand J. Bleckmann, M. D.

19 (Address) 220 E. Eden Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: June 4 1930

20 UNDERTAKER: Joseph Syfer ADDRESS: 1600 N. Pine St.

Type or write very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 57722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 57722

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., 22-31 Ward)

2-FULL NAME Henry Daniels.(C)

(a) RESIDENCE NO. 24 N. Churchill St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45	---		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) South Carolina
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Edna Walker.(C)
(Address) 24 N. Churchill St.

15 Filed ..., 19... Registrar

3-1930 HAWKSON JONES, M.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Compound fracture of both lower legs
Occidental fall.
Pulmonary Embolism.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? U. Md. Coat Pier April 28, 1930

Did an operation precede death? Yes. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible], M. D.

6/2, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion

DATE OF BURIAL June 3 1930

20 UNDERTAKER J. L. Burns & Son

ADDRESS Mt. Lawn

Spec.—8-16-29—L. F. S.—100 Bks.

E 57723

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/E 57723

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 18-29

CITY OF BALTIMORE: (No. 1003 W. Lombard ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James J. Murphy.

(a) RESIDENCE NO. 1003 W. Lombard ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 3 mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary A. Murphy.

6 DATE OF BIRTH (month, day, and year) February 6th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor.

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Johanna.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Mary A. Murphy

(Address) 1003 W. Lombard St.

15 Filed JUN 3 1930 C. HARPER JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 1. 1930, to June 2. 1930, that I last saw h.im alive on June 2. 1930, and that death occurred, on the date stated above, at 7.10 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 3 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Laryngitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam Etc.

(Signed) J. Washburton, M. D.

6/3/30 (Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	June 5th 1930
20 UNDERTAKER	ADDRESS
John J. Cowan & Son	901 Hillen St.

Important. See instructions on back of certificates. Statement of occupation is very

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57724

CERTIFICATE OF DEATH

90 E 57724

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1208 W Fayette ST. 18-11 (WARD)

2—FULL NAME Sadie M Serio

(a) RESIDENCE NO. 1208 W Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 2 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 1st 1915.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15.	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Serio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Carolina Sarullo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mr Joseph Serio
(Address) 1208 W Fayette St

15 Filed ....., 19 ..... Registrar

C. HARRISON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to June 2, 1930, that I last saw h[er] alive on June 2, 1930, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

Bronco-Pneumonia (duration) yrs. 16 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. Artigiani, M. D.

19 (Address) 204 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	June 4th 1930

20 UNDERTAKER John J Cowan & Son. ADDRESS 901 Hollins St

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 57725

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57725

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2001 W. Lexington St. (St.) 70-27 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Lynam

(a) RESIDENCE No. 2001 W. Lexington St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of John Lynam

6 DATE OF BIRTH (month, day, and year) Unknown 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Connors

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Christ Lynam

(Address) 2001 W. Lexington St.

15 Filed 19 Per Registrar C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930 to June 1, 1930

that I last saw her alive on June 1, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Chas. O'Connor M.D.

6/2/30 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cemetery

DATE OF BURIAL 6/4 1930

UNDERTAKER John J. Cowan & Son.

ADDRESS 901 Hollins St.

IMPORTANT. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 37726 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 100 001 E 57726

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. Gibson

(a) RESIDENCE NO. Bassett Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Oct 20 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Betsy Harbour

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 Filed JUN 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-2-1930

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to June 2, 1930, that I last saw h[illegible] alive on June 2, 1930, and that death occurred, on the date stated above, at 11 19 P. m.

The CAUSE OF DEATH* was as follows:

Benigne prostatic hypertrophy - obstruction nephropathy

(duration) 11 yrs. mos da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Ext. [redacted].

(Signed) [signature], M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bassett, Va. DATE OF BURIAL June 4 1930

UNDERTAKER L. H. Skinner ADDRESS Rocky Mount, Va.

IMPORTANT. See instructions on back of certificates. STATEMENT OF OCCUPA-

Spec.—8-16-29—L. F. S.—100 Bks.

E 57727 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57727

CERTIFICATE OF DEATH

74-001

REGISTERED NO. 14-78

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Linden Avenue ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth E. Hogendorp

(a) RESIDENCE NO. 2013 Linden Avenue ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 11 mos. 17 ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) June 15 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	72	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Elias Hogendorp

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Holland

12 MAIDEN NAME OF MOTHER Carolina Kuster

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Emma A. W. Hogendorp
(Address) 2013 Linden Avenue

15 Filed 3-1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/2/30

17 I HEREBY CERTIFY, That I attended deceased from Apr 12, 1926, to June 2, 1930, that I last saw h[illegible] alive on June 2, 1930 and that death occurred, on the date stated above, at 10:50 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

at least (duration) 4 yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary) Cerebral haemorrhage (repeated) (duration) 4 yrs. 1 mos. 21 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spastic paralysis

(Signed) Chas C. Judd, M. D.

. 19 (Address) 8 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 6/4 19 30

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57728

CERTIFICATE OF DEATH.

31

E 57728

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST 17-24 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Robert Cobbs

(a) RESIDENCE No. 579 Greenwillow st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
34 33				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Wallace Cobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Carrie Cobbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Records

(Address)

Filed JUN 3 - 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to May 30, 1930, that I last saw him alive on May 30, 1930, and that death occurred, on the date stated above, at 4.55 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos. Herndon Jr., M. D.

6-1, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUN 3 - 1930 19

20 UNDERTAKER Commissioner Health

ADDRESS

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57729

E 57729

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto. City Hosp.

CITY OF BALTIMORE: (No. ..... ST. 8-16 WARD)

2-FULL NAME Charles Whitfield

(a) RESIDENCE NO. 2047 Llewlyn ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of -

6 DATE OF BIRTH (month, day, and year) July 4, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54	55	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Henrietta ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Records of
(Address) Balto. City Hosp. UNIVERSITY OF MARYLAND

15 Filed ..... 19 ..... HAMILTON JONES, M. D. Registrar

3 1930 4701

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-1-30

17 I HEREBY CERTIFY, That I attended deceased from 5-27-30, 19..., to 6-1-30, 19...,
that I last saw him alive on 6-1-30, 19...,
and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(duration) more than 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis. Chronic (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & examination.

(Signed) Dave Padgett, M. D.

6-2 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER Comm Missioner Health.

DATE OF BURIAL 19

ADDRESS

JUN 3 - 1930

How to fill very important. See instructions on back of certificates.

Name and residence of occupa-

Spec.—1-30—M. & T.—260 Blks.

E 57730

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

123 E 57730

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. St. 13 WARD)

2-FULL NAME Julius Weber

(a) RESIDENCE NO. 1102 S. Kenwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sadie Weber

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter O.S.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Weber

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Wagner

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Hospital Record
(Address) .....

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-1-30

17 I HEREBY CERTIFY, That I attended deceased from 5-30, 1930, to 6-1, 1930, that I last saw h[illegible] alive on 6-1, 1930, and that death occurred, on the date stated above, at 7[illegible] P. m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis and Cholelithiasis

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 5-30-30

Was there an autopsy? No Removal of Gall Bladder

What test confirmed diagnosis? Operation

(Signed) L. U. Lumpkin, M. D.

6-1, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem. DATE OF BURIAL June 4 1930

20 UNDERTAKER John Ulrich ADDRESS 2008 Aliceanna

6-1-1930 R.P.L.

Physician very important. See instructions on back of certificates. Statement of Occupa-

Spec.—1-30—M. & T.—250 Blks.

E 57731 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 57731

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 Hurleys Lane 20-70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ollie Menard

(a) RESIDENCE NO. 528 Hurleys Lane WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of F F Menard

6 DATE OF BIRTH (month, day, and year) 2/05/1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Reinhold Waldhaus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amalie Melcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs F F Menard

(Address) 528 Hurley ave

15 Filed JUN 3 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2-1930

17 I HEREBY CERTIFY, That I attended deceased from August, 1929, to June 1, 1930, that I last saw h alive on June 1, 1930, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Lash, M. D.

June 3, 1930 (Address) 2605 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL June 6 1930

UNDERTAKER John Merrick

ADDRESS 2008 Aliceanna

See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Clarence Campbor

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57732

CERTIFICATE OF DEATH.

118 E 57732

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. St. 18-26 WARD)

2-FULL NAME Clarence Canfor

(a) RESIDENCE NO. 916 W. Fayette St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed June 3 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-27 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-26, 1930, to 5-27, 1930, that I last saw h[illegible] alive on 5-27, 1930 and that death occurred, on the date stated above, at 12.55 p m.

The CAUSE OF DEATH* was as follows:

Hernia - Inguinal - Strangulated

(duration) 6-8 yrs. mos 2 hrs.

CONTRIBUTORY (Secondary) Carcinoma (duration) yrs. mos. 6 mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5/26/30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. C. Canfield M. D.

5-27 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS JUN 3 - 1930

For W. R. WOODALL

IMPORTANT See instructions on back of certificates. Exact statement of OCCUPATION is very important

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 57733

E 57733

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Belvedere & Greenspring Care Hebrew Home for Aged & Infirm

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD 24

2-FULL NAME Sarah Pushkin

(a) RESIDENCE NO. Belvedere & Greenspring ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1833

7 AGE: Years 97 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed ....., 19.... Registrar

SIGMUND FEINBLATT SUPERINTENDENT

C. HAMILTON JONES, M.D.

3-14-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1930

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to June 1, 1930, that I last saw h[illegible] alive on June 1, 1930, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos 12 ds.

CONTRIBUTORY (Secondary) none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Seidel, M. D.

6/2 1930 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt. Carmel — DATE OF BURIAL 6-4-1930

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

THIS is very important See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-12-23—M&T—500 Bks.

E 57734 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57734

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Home for Infirm REGISTERED NO. 44

CITY OF BALTIMORE: (No.) Levindale (ST.) 27-54 (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Bernstein

(a) RESIDENCE NO. Levindale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46	~~1 da~~			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Confectionery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isreal Bernstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Home Record
(Address)

15 Filed JUN 3 1930, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1930

17 I HEREBY CERTIFY, That I attended deceased from March 20, 19 30, to June 1, 19 30, that I last saw h alive on June 1, 19 30 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & X Ray

(Signed) W Edmund Levin, M. D.

, 19 (Address) Levindale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Put. Carmel	6-4- 1930
UNDERTAKER	ADDRESS
Jack Lewis	1431 Pratt St

IMPORTANT See instructions on back of certificates. Exact statement of OCCUPATION is very important and if any of these items be not properly classified, it may be returned for correction.

Cor.—10-10-29—A Co.—100 Bks.

57735

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57735

CERTIFICATE OF DEATH

32

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 10-14 Ward)

2-FULL NAME Eva C. Beardsworth

(a) RESIDENCE NO. 1023 Somerset St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 24/1926

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	3	9	9 8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Peter J. Beardsworth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Staten Island

12 MAIDEN NAME OF MOTHER Bessie I. Lewis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant George W. Zirkler
(Address) 1737 E. Eager St

15 Filed JUN 3 - 1930 H. Peet Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Respiratory Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tubercular Meningitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? at St. Joseph Hosp

What test confirmed diagnosis?

(Signed) J. H. Peet, M. D.

6/3/30 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL June 4 1930

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 57736

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

CERTIFICATE OF DEATH.

E 57736
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard + Green St.s) 17-24 (WARD)

2-FULL NAME Baby Girl Mathews

(a) RESIDENCE NO. 1314 Division St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/29/30

7 AGE Years Months Days If LESS than 1 day 19 hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 00
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James H. Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Ethel Blackwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/30 1930

17 I HEREBY CERTIFY, That I attended deceased from 5/29/30 . 19 . to 5/30/30 . 19 .
that I last saw h[illegible] alive on 5/30/30 . 19 E. S. T.
and that death occurred, on the date stated above, at 8[10] A. m.

The CAUSE OF DEATH* was as follows:

Premature Infant.
(32 wks).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Placental Previa

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis H. Douglass M. D.

6/2, 1930 (Address) Louis. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health

JUN 3 - 1930

FOR WM. S. WOERLE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57737

CERTIFICATE OF DEATH.

161-001

E 57737

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 204 S. Grundy St., 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gioga

(a) RESIDENCE NO. 204 S. Grundy St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmle

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 2/30

7 AGE — Years | Months | Days | IF LESS than 1 day 10 hrs. 25 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER Lawrence Gioga

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Italy

12 MAIDEN NAME OF MOTHER Valentino

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Italy

14 Informant Lawrence Gioga

(Address)

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 June 2/30

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 2, 1930, that I last saw her alive on June 2, 1930, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth 10½ hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Dr. Artigiani, M. D.

, 19 (Address) 2942 Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

JUN 3 - 193

Every important. See Instructions on back of certificates.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

E 57738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-001

E 57738

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hosp (St.) 1-24 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Lippin

(a) RESIDENCE NO. Lippin Corner St., Anne Arundel Co Md.
(Usual place of abode) (Ward) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days: 0 | If LESS than 1 day, hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): 0 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Lippin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Augusta Blakewitch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Hosp Records

15 Filed JUN 3 1930, 19 C. HAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/2/30 19

17 I HEREBY CERTIFY, That I attended deceased from 6/2/30, 19, to 6/2/30, 19, that I last saw h alive on 6/2/30, 19, and that death occurred, on the date stated above, at 7 45 p.m.

The CAUSE OF DEATH* was as follows:

Premature Abortion

26 Wks.

Cause undetermined

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross AA Co Md — DATE OF BURIAL: June 4 1930

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

Spec.—1-30—M. & T.—250 Blks

E 57739

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57739

CERTIFICATE OF DEATH.

+ 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial ST. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary McCoy

(a) RESIDENCE NO. 28 Md Ave; Chesfield, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Washington McCoy

6 DATE OF BIRTH (month, day, and year) Oct 14-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	20	19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Toad

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Doue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Husband

(Address) 28 Md Ave. Chesfield Md

15 Filed JUN 3 1930 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1930

17

I HEREBY CERTIFY, That I attended deceased from May 23, 1930 to June 3 1930,

that I last saw her alive on June 3 1930,

and that death occurred, on the date stated above, at 4:30 A.M. Daylight Saving

The CAUSE OF DEATH* was as follows:

Carcinoma, Head of Pancreas

not known

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Finding + Symptoms

(Signed) Hilda Sampsonard, M. D.

June 3 1930 (Address) Union Mem Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chesfield Md. DATE OF BURIAL June 3rd 1930

20 UNDERTAKER Leo G. Crook ADDRESS 1230 Park Ave

FROM IN very Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 57740 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57740

CERTIFICATE OF DEATH.

+ 175

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST., 12 WARD)

REGISTERED NO. 42-49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward McCleary

(a) RESIDENCE NO. 33 Willow Ave. ST., Towson, Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 10 05

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John McCleary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records.

(Address)

15 Filed June 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 3, 1930, that I last saw h.. alive on June 3, 1930, and that death occurred, on the date stated above, at 1.35 P m.

The CAUSE OF DEATH* was as follows:

Acute pancreatitis

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Nicholas Lamphear, M. D.

June 3, 1930 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill Cem. DATE OF BURIAL June 3, 1930.

20 UNDERTAKER John Burns Son ADDRESS Towson

FOR IF VERY IMPORTANT. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57741

CERTIFICATE OF DEATH

90 E 57741

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1618 N. Caroline St., 9-17 Ward)

2-FULL NAME John Philip Orth

(a) RESIDENCE NO. 1618 N. Caroline St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret M. Orth

6 DATE OF BIRTH (month, day, and year) Jan 25/1861

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	69	4	7 6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Manager (retired)
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer Armstong & Cator

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Geo. Philip Orth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Nidan, Germany

12 MAIDEN NAME OF MOTHER Elizabeth Schwartz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) On Main, Germany

14 Informant Margaret M. Orth.
(Address) 1618 N. Caroline St

15 Filed 3-1930 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to n1s death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. H. Cator, M. D.

6/2/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL June 4, 30

20 UNDERTAKER Chas. S. Black — ADDRESS 742 W North Ave

Spec.—1-30—M. & T.—250 Blks.

E 57742 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57742

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1346 Division ST. 17-24 WARD)

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bell

(a) RESIDENCE NO. 1346 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/1/30

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Elmer Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ruth Lawrence

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Ruth Bell (Address) 1346 Division St

15 JUN 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 30

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 2, 1930, that I last saw him alive on June 1, 1930, and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows: Hemorrhage

Premature Birth

(duration) 0 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) 0

(duration) 9 yrs. 0 mos. ds.

18 Where was disease contracted if not at place of death? 0

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John C Stewart M. D.

6/2/30 (Address) 704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL June 4 1930

20 UNDERTAKER Edward F. Steusloff ADDRESS 1128 Eddy

Spec.—1-30—M. & T.—250 Blks. See instructions on back of certificates. Items are very important.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57743

CERTIFICATE OF DEATH

90 E 57743

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) 313 N Gilmore St., 15-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Richardson

(a) RESIDENCE NO. 313 N Gilmore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary L Richardson

6 DATE OF BIRTH (month, day, and year): March 28-1843

7 AGE: Years 87 Months 2 Days 3

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer): 86

(c) Name of employer

9 BIRTHPLACE (city or town) Fredrick

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Richardson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Fredrick Md

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Isaac L Richardson

(Address) 313 N Gilmore St

C. HAMPSON JONES, M. D.

15 Filed JUN 3 1930 16 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1-1930 19

17 I HEREBY CERTIFY, That I attended deceased from May 30 1930, to June 1 1930, that I last saw h.. alive on May 31 1930, and that death occurred, on the date stated above, at 5:20 p.m.

The CAUSE OF DEATH* was as follows:

1 Apoplexy

2 Art Sclerosis

(duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ..... yrs. 5 mos. ..... ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Chas C Chandler, M. D.

(Address) 3013 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loud. Auburn Cem

Date of Burial: June 4 1930

20 UNDERTAKER: Samuel S. Handley

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57714

CERTIFICATE OF DEATH

66 E 57714

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Jail St., 4-25 Ward)

2-FULL NAME James C. Van Evera

(a) RESIDENCE NO. 207 North Queen St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE: Years 57 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Cigars
(c) Name of employer: Yorkport

9 BIRTHPLACE (city or town): Yorkport
(State or country)

PARENTS

10 NAME OF FATHER: J. C. Van Evera

11 BIRTHPLACE OF FATHER (city or town): N. York.
(State or country)

12 MAIDEN NAME OF MOTHER: T. Reinp

13 BIRTHPLACE OF MOTHER (city or town): N. Y.
(State or country)

14 Informant: J. E. Van Evera
(Address): 207 N. Queen

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): January 30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Diabetes Mellitus
Cardiac Insufficiency
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. J. Riley, M. D.

, 1931 (Address) 1639 Bryden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 5-5 19

20 UNDERTAKER: Cook — ADDRESS: 127 E Fayette St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 57745 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57745

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals 9-46 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. WARD)

2-FULL NAME Madeline Carroll

(a) RESIDENCE NO. 1502 Abbottson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1859 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 3-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-2-30

17 I HEREBY CERTIFY, That I attended deceased from 3-19-29, 19..., to 6-2-30, 19..., that I last saw her alive on 6-2-30, 19..., and that death occurred, on the date stated above, at 1:25 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute.

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

6-2, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 5 1930
20 UNDERTAKER	ADDRESS
Wm Cook	1207 N Paul

FOR A VERY important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57746

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57746

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 23-34

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bradley

(a) RESIDENCE NO. 1508 Marshall ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of George T. Bradley

6 DATE OF BIRTH (month, day, and year) July 14, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79 80		10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Susan Hickman

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Records of (Address) Baltimore City Hospitals

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-2-30

17 I HEREBY CERTIFY, That I attended deceased from 5-29-30, 19..., to 6-2-30, 19..., that I last saw her alive on 6-2-30, 19..., and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute. more than 1 (duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & hypertension (duration) unknown yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

6-3, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL June 5, 1930

20 UNDERTAKER A. Howard Evans ADDRESS 38 E. Fort Ave

FROM U very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57747 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57747

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2-4 ST. WARD)

2-FULL NAME William Dell

(a) RESIDENCE NO. 1824 Bank ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M.

6 DATE OF BIRTH (month, day, and year) Sept. 29, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47	48	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Records of
(Address) B. C. H.

3 File 1230 G HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-2-30

17 I HEREBY CERTIFY, That I attended deceased from 5-29-30, 19..., to 6-2-30, 19..., that I last saw h... alive on 6-2-30, 19..., and that death occurred, on the date stated above, at 12:40P m.

The CAUSE OF DEATH* was as follows:

Nephritis, acute parenchymatous.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padget, M. D.

6-2, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery — DATE OF BURIAL June 5 1930

20 UNDERTAKER Henry Sander & Sons. Inc. — ADDRESS Baltimore St & Broadway

FILL IN very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 57748

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57748

CERTIFICATE OF DEATH.

+ 139

1-PLACE OF DEATH St Agnes Hospital — REGISTERED NO. .....

CITY OF BALTIMORE: (No. Caton & Wilkens Avenues 70-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah Tyne

(a) RESIDENCE NO. 260 South Ave - Bridgeton NJ WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female.	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Tyne

6 DATE OF BIRTH (month, day, and year) Jan. 3. 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
46	43	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Watson A. Caggins

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Harriet Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant John Tyne

(Address) 260 South Ave Bridgeton NJ

15 Filed 3-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-3- 1930

17

I HEREBY CERTIFY, That I attended deceased from 5-23, 1930, to 6-3, 1930,

that I last saw her alive on 6-3, 1930,

and that death occurred, on the date stated above, at 2 30 P m. Standard

The CAUSE OF DEATH* was as follows:

Cerebral Embolism - 10 days PD

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hysterectomy - appendectomy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 5-24-36

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) L. Clarence Cohn M. D.

6 3, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bridgeton New Jersey — DATE OF BURIAL June 4, 1930

20 UNDERTAKER Robert H. Cook — ADDRESS 1003 Walnut St

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57749 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57749

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 12-14 ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Price

(a) RESIDENCE NO. 535 Bowen Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 70

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Susan

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 6-3-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-1-30

17 I HEREBY CERTIFY, That I attended deceased from 9-14-27, 19..., to 6-1-30, 19...,

that I last saw her alive on 6-1-30, 19...,

and that death occurred, on the date stated above, at 1:02 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

More than (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetic coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. of lab. 4.8.2.5

(Signed) Paul Padget, M. D. 10

6-2-1930 (Address) Balto City Hosp. 9 1

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 6/4/1930

20 UNDERTAKER Mrs. Geo. L. Holland

ADDRESS 1631 Druid Hill

B-1930

IMPORTANT. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 57750

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 57750

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 1026 W. Franklin ST. 18-26 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Frazier

(a) RESIDENCE NO. 1026 W. Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Frazier

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Laura Frazier

(Address) 1026 W Franklin

15 Filed JUN 4 1930 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-1- 1930

17

I HEREBY CERTIFY, That I attended deceased from 5-30-, 1930, to 6-1-, 1930,

that I last saw h alive on 5-31-, 1930,

and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. H. Caudill, M. D.

6-2-, 1930 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion DATE OF BURIAL June 4 1930

20 UNDERTAKER John H. Toadvine ADDRESS 1027 Druid Hill

TION is very important See instructions on back of certificates. Exact statement of OCCUPA-

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5775L

CERTIFICATE OF DEATH

118-002

E 5775L

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3307 Fairview Ave) (St.) (Ward) 15-61

2-FULL NAME Charles O. Conway.

(a) RESIDENCE NO 3307 Fairview St., Ward 26.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) Oct 30-1929

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	7	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Evanston Ill.
(State or country)

PARENTS

10 NAME OF FATHER Wm H. Conway

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Maurice O. Connell

13 BIRTHPLACE OF MOTHER (city or town) London
(State or country) Eng.

14 Informant Mrs Catherine Conway
(Address) 3307 Fairview

15 Filed ... 1930 ... C. HAROLD JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular.

(Signed) June 2nd F. B. Smith, M. D.

(Address) Coroner.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 4 1930

20 UNDERTAKER Henry W. Mearkle & Son

ADDRESS 805 N. Calvert St

Spec.—2-29-28—L. F. S.—500 Blks.

E 57752 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

129 ✓ E 57752

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 24-344

CITY OF BALTIMORE: (No. 133 E. Randall St. ST. — WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Edward Schroder

(a) RESIDENCE NO. 133 E. Randall St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katie Schroder

6 DATE OF BIRTH (month, day, and year): Jan. 16 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Sigismen Schroder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Denmark

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Sanks

(Address): 1703 Hanover St.

15 Filed 4 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1929, to May 31, 1930, that I last saw him alive on May 31, 1930 and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis &
chronic aortic regurgitation of heart

(duration) 1 yrs. 4 mos. 4 ds.

CONTRIBUTORY (Secondary): Pneumonia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Adam Heilbrun, M. D.

6/4, 1930 (Address) 124-126 Hanover St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: 6/4 1930

a UNDERTAKER: J. Fee Wm. Smith — ADDRESS: 130 E. Fort

Instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57753 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 57753

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1823 Penn Ave ST. 14-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifford O. Turner

(a) RESIDENCE NO. 1823 Penn Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Anna Turner

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Ice Store

(c) Name of employer Goldsborough Ice Mfg. Co.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Geo Co Md

12 MAIDEN NAME OF MOTHER Minnie Byrd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Minnie Turner

(Address) 526 N. Mechanic

15 Filed ... 1930 ... 19 Mar C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-3-30

17 I HEREBY CERTIFY, That I attended deceased from 5-14-, 1930, to 6-4, 1930,

that I last saw him alive on 6-2, 1930,

and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Otitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Wm. A. Fair, M. D.

(Address) 1200 Penn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cem

DATE OF BURIAL 6/4 1930

UNDERTAKER Samuel Beasley

ADDRESS 578 N Bidale

FROM A very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Schlueder
3307 E. Balto

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57754

CERTIFICATE OF DEATH

113 E 57754

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3410 Leaverton Ave ST. 26-2 WARD)

2—FULL NAME Roger B. Russell

(a) RESIDENCE NO. 3410 Leaverton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Roger B. Russell

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Schlotter

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mary Russell (Mother)
(Address) 3410 Leaverton Ave

15 Filed JUN 4 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1930 to June 3, 1930, that I last saw her alive on June 3, 1930 and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Insufficient Food Intake

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. C. Schlueder, M. D.

June 4, 1930 (Address) 3307 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	June 4 1930
20 UNDERTAKER	ADDRESS
H. Sander Sons Inc.	1710 Park Ave

(See instructions on back of certificate.)

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57755

CERTIFICATE OF DEATH

161-001

1-PLACE OF DEATH

REGISTERED NO. E 57755

22-30

City of BALTIMORE: (No. 649 Portland St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Medzianowski

(a) RESIDENCE NO. 649 Portland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 30. 1930

7 AGE — Years — Months 0 Days 4 IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NO

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Frak Medzianowski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Lithvania

12 MAIDEN NAME OF MOTHER Veronk Sadaveckas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lithvania

14 Informant V. Sadaveckas

(Address) 649 Portland St.

15 Filed JUN 4 - 1930, 19 RAYMOND JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to June 3, 1930, that I last saw h.. alive on June 3, 1930, and that death occurred, on the date stated above, at 5 00 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

6/4, 1930 (Address) 624 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: June 4. 1930

20 UNDERTAKER: John Grebliauckas — ADDRESS: 423 S Paca St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 57756

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57756

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2317 E. Fairmount St. (Ward) 10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Mary Lurz

(a) RESIDENCE NO. 2317 E. Fairmount St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): June 2. 1929

7 AGE: Years 1 Months Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Edward J. Lurz

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Rose M. Spezel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant: Edw. J. Lurz Father

(Address) 2317 E. Fairmount Ave

15 Filed 6-4-1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1930

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to June 3, 1930, that I last saw h[illegible] alive on June 3, 1930, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos 3 da.

CONTRIBUTORY (Secondary) Congenital Asthenia

(duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John L. Valentine M. D.

, 193 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: June 4 1930

20 UNDERTAKER: Lilly & Zeiler Inc — ADDRESS: 403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 57757

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57757

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 114 N. Durham ST., 69 WARD)

2—FULL NAME Conrad J. Albrecht

(a) RESIDENCE NO. 114 N Durham ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda ?

6 DATE OF BIRTH (month, day, and year) Feb 13-1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	3	20	19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Anthony Albrecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Anna Eysenhofer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Albrecht

(Address) 114 N Durham

15 Filed ....., 19 ..... C. HAMPSON JONES, M. D. Registrar

M 4 - 1530

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 - 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to June 2, 1930, that I last saw h... alive on June 2, 1930 and that death occurred, on the date stated above, at 8 15 P. m. E.S.T

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy

(Signed) Edward J. Leoni, M. D.

6/3, 1930 (Address) 413 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: June 6 1930

20 UNDERTAKER: Lilly & Sons — ADDRESS: 408 S. Wolfe St

Cor.—10-10-29—A Co.—100 Bks.

E 57758

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

177 E 57758

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 16-37 Ward)

2-FULL NAME Evelyn Rose Updegraff

(a) RESIDENCE NO. 3710 Mt Pleasant Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 25/28

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	1	9	9 8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Robert Updegraff

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Kotchenreuther

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Hopkins Record
(Address)

15 Filed 4-1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 3/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lead Poisoning?

Meningitis?

Anemia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) "History of eating paint"

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) J. H. Cullen, M. D.

6/4/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL June 6 1930

20 UNDERTAKER Lilly & Zeiler inc ADDRESS 403 S. Hoffe St

Spec.—1-30—M. & T.—250 Blks.

E 57759

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57759

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO. 13259

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Sinai Hosp. (ST.) (WARD)

2-FULL NAME Edward L. Frank

(a) RESIDENCE NO. Sinai Hosp. ST., WARD

(Usual place of abode) Esplanade Apts.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

lifetime

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Lorie S. Frank

6 DATE OF BIRTH (month, day, and year): Dec. 5, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Mfr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt. Md.

PARENTS

10 NAME OF FATHER: Leon Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Regina Fleishman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. A. Bonsit

(Address) Esplanade Apts

15 Filed 6-4-1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-24-30, 1930, to 6-3, 1930, that I last saw h[illegible] alive on June 3, 1930, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chr. nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel J. Hauser M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balt. Hebrew Cem.

DATE OF BURIAL: 6/5/1930

20 UNDERTAKER: Harry Sonneborn & Co

ADDRESS 1902 Eutaw Place

FRONT—Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 57760

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57760

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1120 N Gilmor ST. 16-22 WARD

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Frances Jackson

(a) RESIDENCE No. 1120 N Gilmor ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced: ~~HUSBAND of~~ or) WIFE of Jacob Jackson

6 DATE OF DATE OF BIRTH (month, day, and year): ? ? 1869

7 AGE — Years: 61 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Launders

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Caroline Co Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Unknown

14 Informant: Rev Wm Jackson
(Address) 1120 N Gilmor

15 Filed ..... 1930 ....., 19 ..... C. BAGLEY, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2 1930

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to June 2, 1930, that I last saw h alive on June 2, 1930, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) —
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. F. Howell M. D.

, 19 (Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn June. — DATE OF BURIAL: 5. 1930

20 UNDERTAKER: Joseph A Lively — ADDRESS: 409 N Mount St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57761

90 E 57761

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1412 Druid Hill Ave 44-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie L Stewart

(a) RESIDENCE NO. 1412 Druid Hill Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Stewart

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE: Years 45 Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Middleburg

(State or country): Virginia

PARENTS

10 NAME OF FATHER: John Harris

11 BIRTHPLACE OF FATHER (City or town): Virginia

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Virginia

14 Informant: Charles Stewart

(Address): 1412 Druid Hill Ave

15 Filed ....., 19..... C. HAMPSON JONES, M. D. Registrar

File

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to June 2, 1930

that I last saw her alive on June 1, 1930

and that death occurred, on the date stated above, at 5:00 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis Ch

(duration) yrs. 4 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? medical

(Signed) H. Atwell Jones, M. D.

19 (Address) 1123 Penna Ave Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn June 5.

Date of Burial 1930

UNDERTAKER: Joseph A Sisely

ADDRESS 4092 Mount St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 57762 HEALTH DEPARTMENT—CITY OF BALTIMORE É 57762

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1200 Myrtle Ave WARD 17-24

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. Kennard

(a) RESIDENCE NO. 1200 Myrtle Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) -- 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Alger Kennard

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Rachel Baker

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Sadie O'Neil (Address) 1200 Myrtle Ave

15 Filed JUN 4 1930 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-1-1930

17 I HEREBY CERTIFY, That I attended deceased from May 20 1930, to June 1 1930, that I last saw h[illegible] alive on May 31 1930, and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:

Senile Arteriosclerosis

Chronic Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) C. A. Mabell M. D.

(Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL June 4 1930

20 UNDERTAKER Lottie Gross — ADDRESS 1408 Richmond Ave

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57763

CERTIFICATE OF DEATH

92 V

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. 2908 Ulman ave / 5-38 ST.: WARD)

(If death occured in a hospital or institution, give its NAME instead of Street and number and fill out No. 18.)

2-FULL NAME Mollie Satinsky. or Satisky

(Residence in Baltimore: No. 2908 Ulman ave St.: 2F yrs. mos. ds.)

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	white	Married

6-DATE OF BIRTH ~~24~~ — 1885 Unkown, 1
(Month) (Day) (Year)

7-AGE 45 yrs. 3 mos. 4 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Russia

PARENTS

10-NAME OF FATHER: Joseph Satinsky

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Unkown

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Israel Satinsky

(Address) 2908 Ulman ave

JUN 4 - 1930 Filed ..... 191 C. HAMPTON JONES, M. REGISTRAR Per .....

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June — 4 — , 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May - 30 , 1930 . to. June - 4 - 1930 . that I saw her alive on June - 4 - , 1930 . and that death occurred, on the date stated above. at 5 a. m.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion

not known-
(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Herman Seidel M. D.

June - 4 - 1930 (Address) 2404 Entawpl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Hebrew Southern ave — DATE OF BURIAL: June 4 1930

20-UNDERTAKER: S Levinson Bro — ADDRESS 1121 E Balto St

Spec.—1-30—M. & T.—250 Blks.

E 57764

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 57764

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6704 Faith Ave ST. 26-37 WARD)

2-FULL NAME Samuel L. Lambert

(a) RESIDENCE NO. 6704 Faith Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Della V. Lambert

6 DATE OF BIRTH (month, day, and year) Aug 23 1861

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood- 014

(b) General nature of industry, business, or establishment in which employed (or employer) Worker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fla

PARENTS

10 NAME OF FATHER Noah Lambert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Ellen Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Della Lambert
(Address) 6704 Faith Ave

15 Filed C. HAMPSON JONES, M. D. Registrar
N 4 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1/30

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to June 1, 1930, that I last saw h[illegible] on June 1, 1930, and that death occurred, on the date stated above, at 10 35 P m.

The CAUSE OF DEATH* was as follows:

Valvular dis Heart

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Physical signs

(Signed) C Brunet, M. D.

6/3/30 (Address) 408 S Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakwood — DATE OF BURIAL June 4 1930

20 UNDERTAKER Philip Hennig — ADDRESS 2016 Eden St.

(FROM IS VERY Important. See instructions on back of certificates.)

Spec.—1-30—M. & T.—250 Blks

57765 E

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 57765

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE (No.) 1813 h Collington Ave (Ward) 8-16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Louisa A. Kammer

(a) RESIDENCE NO. 1813 h Collington Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Michael A. Kammer.

6 DATE OF BIRTH (month, day, and year) Sept 7 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30 years	8.	8.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer home

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Fredrick Bach.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Olga Eckert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Michael A. Kammer 1813 h Collington Ave

15 Filed 1930 C. HAYDON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1930

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to June 7, 1930, that I last saw her alive on June 2, 1930, and that death occurred, on the date stated above, at 5.02 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Allen Erwin M. D.

6/8, 1930 (Address) 2052 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Baltimore | DATE OF BURIAL June 9 1930

20 UNDERTAKER J. Vernon Lechner | ADDRESS Holbrook

FROM IS very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Spindler

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57766 E 57766

CERTIFICATE OF DEATH. + 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. Gen. Hosp. (St.) 11-24 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Philip Spindler

(a) RESIDENCE NO. Harford Rd. (St.) (Gamey) (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ## yrs. mos. 1 ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ late Dorothea E. Spindler

6 DATE OF BIRTH (month, day, and year) May 1/48

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82 yrs.	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Cabinet Maker

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Spindler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz. Eckert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record. (Address)

15 Filed JUN 4 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to June 4, 1930, that I last saw h[illegible] alive on June 4, 1930, and that death occurred, on the date stated above, at 1:00 p.m.

The CAUSE OF DEATH* was as follows:

Hypertension, Arteriosclerosis

Diabetes

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

Uremia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) C. Adams Jones M. D.

6/4/30 (Address) 1300 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL June 6 1930

20 UNDERTAKER Philip Herring

ADDRESS 2016 Orleans St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—350 Blks.

E 57767 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57767

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. M. ST. 11-24 WARD) 10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Nelson

(a) RESIDENCE NO. 840 N. Eutaw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry

6 DATE OF BIRTH (month, day, and year) Sept. 27, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23 24	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Charles Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Rahulda Hoover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 6-4-1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-3-30

17 I HEREBY CERTIFY, That I attended deceased from 6-2-30, 19..., to 6-3-30, 19...,

that I last saw her alive on 6-3-30, 19...,

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic rheumatic (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History; exam.

(Signed) Paul Padget, M. D.

6-4, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Keyser, West Virginia	June 4th 1930
20 UNDERTAKER Henry Hoeck Sons Inc.	ADDRESS 130 E Eager St

FROM IF very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57768

E 57768

CERTIFICATE OF DEATH

129

REGISTERED NO. 2863

1-PLACE OF DEATH

City of BALTIMORE: (No. 3723 Marmon Ave St. 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine A Beam

(a) RESIDENCE NO. 3723 Marmon Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ (or) WIFE of James P. Beam

6 DATE OF BIRTH (month, day, and year) July 18 - 1845

7 AGE 84 Years 10 Months 15 Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Washington L Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Miller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Samuel Beam

(Address) 3723 Marmon Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

By D.K.P.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 29 1930, to June 3, 1930, that I last saw h alive on April 4, 1930, and that death occurred, on the date stated above, at 1010 A m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar Resolution

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) old age

(duration) 44 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. H. Jones M. D.

6/4 1930 (Address) 4909 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emory Chapel — Date of Burial June 6 1930

20 UNDERTAKER Edward L. Tipton — ADDRESS Hampstead Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57769

90 E 57769

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1830 E. Monument St., 7-4 Ward)

2-FULL NAME Lucy E. Clarkson

(a) RESIDENCE NO. 1830 E. Monument St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph L. Clarkson

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: 70 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER James Woods

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Norfolk, Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) ll

14 Informant: Wm. G. Schaeffer
(Address) 1816 E. Monument St

15 Filed ..... G. HAMPSON JONES, M. D. Registrar
4-1930 Pat

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. Inq. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inqiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Calvert, M. D.

6/2/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: June 5 1930

20 UNDERTAKER: William G. Schaeffer — ADDRESS: 1816 Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57770

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57

E 57770

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 904 Russell ST. 21-31 WARD)

2—FULL NAME Ella Scott —

(a) RESIDENCE NO. 904 Russell ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathaniel Scott

6 DATE OF BIRTH (month, day, and year) — 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 32

(b) General nature of industry, business, or establishment in which employed (or employer) Days work —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland —

PARENTS

10 NAME OF FATHER George Brown

11 BIRTHPLACE OF FATHER (city or town) Baltimore —
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Gray

13 BIRTHPLACE OF MOTHER (city or town) Richmond
(State or country) Virginia

14 Informant Verdella Turner
(Address) 533 N Dee

15 Filed ..... 1939 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/4/30

17 I HEREBY CERTIFY, That I attended deceased from 12/28 1929 to 6/4 1930, that I last saw h alive on 6/4 1930 and that death occurred, on the date stated above, at 10 45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis —
Chronic Nephritis —
Diabetes Mellitus —
(duration) yrs. Chronic mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Urine + Johns Hopkins

(Signed) Dan Draddock, M. D.

6/4 1930 (Address) 1122 N Dee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	June 5 1930
20 UNDERTAKER	ADDRESS
John H. Todkin	1027 Druid Hill Ave.

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60-001

E 57771

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2546 Madison ave ST. 17-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eva Pauline Hard

(a) RESIDENCE NO. 2546 Madison ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Col-	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Hard

6 DATE OF BIRTH (month, day, and year): 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 0?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: Hudson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Annie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Walter Hard

(Address): 2546 Madison ave

15 Filed 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2-1930

17 I HEREBY CERTIFY, That I attended deceased from May 21- 1930, to June 2- 1930, that I last saw h[illegible] alive on June 2- 1930, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Exophthalmic goiter with Cardiac insufficiency

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary): Not known

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas J Keller, M. D.

6/4. 1930 (Address) 2222 W Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: June 5 1930

20 UNDERTAKER: John H. Foakes — ADDRESS 1027 Druid Hill

Important. See instructions on back of certificate. Last statement of OCCUPATION is ...

Cor.—10-10-29—A Co.—100 Blks.

E 57772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 185

E 57772

1-PLACE OF DEATH

City of Baltimore: (No.) U. S. Marine Hospital (St.) 12-51 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eutaterio Reyes

(a) RESIDENCE NO. 322 East 26th St., New York City Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
30	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer) Seaman
(c) Name of employer S. S. Helen

9 BIRTHPLACE (city or town) .....
(State or country) Porto Rico

PARENTS

10 NAME OF FATHER Carmello Reyes

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Records U. S. Marine Hospital
(Address) Baltimore, Md.

15 Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ her death on the day stated above.

The ~~CAUSE OF DEATH~~* was as follows:

Ruptured Liver, traumatic Hepatorrage; Falling Down Hatchway of S.S. (Accidental) (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock & Intra Abdominal Hemorrage (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? Yes Date of 6-3-30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) [illegible], M. D.

6/4, 1930 (Address) 532 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York City, N. Y.	June 4, 1930
20 UNDERTAKER E. Leroy Stiffler, Inc.	ADDRESS 125 E. North Ave.

4-1930

Every item of information required. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

(Johnson)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57773 ✓ E 57773

CERTIFICATE OF DEATH.

90 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4675 Falls St., 27-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Johnson

(a) RESIDENCE NO. 4675 Falls ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marshall

6 DATE OF BIRTH (month, day, and year): Oct. 16-1885

7 AGE: Years 44 Months 7 Days 17 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Mark Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ella Howes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ada Handy

(Address) 4675 Falls Rd.

15 Filed 4-1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3 1930

17 I HEREBY CERTIFY, That I attended deceased from June 31, 1930, to June 3, 1930, that I last saw h[illegible] alive on June 3, 1930 and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Hypertrains Cardiac Vascular Disease

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. O. Lewis, M. D.

, 19 (Address) 2529 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL 6/5/1930

UNDERTAKER: Mrs. Geo. H. Holland — ADDRESS 1631 Druid Hill Ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57774 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57774

CERTIFICATE OF DEATH.

74-08

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 11-4 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Vinju

(a) RESIDENCE No. 629 N. Calvert ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Vinju Nov. 13.

6 DATE OF BIRTH (month, day, and year) Unknown 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Holland

PARENTS

10 NAME OF FATHER Wm. H. Vinju

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Emma ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed 4 1930, 19 C. HAMPSON JONES, M. D.
By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-3-30

17 I HEREBY CERTIFY, That I attended deceased from 4-26-30, 19..., to 6-3-30, 19..., that I last saw him alive on 6-3-30, 19..., and that death occurred, on the date stated above, at 10:05 P.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) ..... yrs. ..... mos. 45 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Hypertension (duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Autopsy exam.

(Signed) Paul Padgett, M. D.

6-4, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL June 6 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore St & Broadway

TION is very important. See instructions on back of certificates. Exact statement of OCCUP

Spec.—1-30—M. & T.—250 Bks.

E 57775 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57775

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 648 Washington Blvd St. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Sakolsky

(a) RESIDENCE NO. 648 Washington Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Samuel Sakolsky

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 77

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Lazarus Fuld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Regina —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant L. Lewis

(Address) 1739 E Balt St

Filed 6-4-1930, 19 C. HAMPSON JONES, M. D.

By APH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4-1930

17

I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to June 4, 1930,

that I last saw h[illegible] alive on June 3, 1930,

and that death occurred, on the date stated above, at 9 30 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic heart disease

Myocardial degeneration

? (duration) yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Meyer Muller, M. D.

, 19 (Address) 2649 Park Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 6-6- 1930

20 UNDERTAKER Jack Lewis, 1739 E Balt

ADDRESS

TION is very important. See instructions on back of certificates. Exact statement of OCCUP

Cor.—12-9-25—A Co.—200 Bks. Coroner Morrissey

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57776

CERTIFICATE OF DEATH.

90 ✓ E 57776

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 10 W. 24th St) (Ward) 27-44

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas P. Vaughan

(a) RESIDENCE NO. 1035 Woodbrights Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or ~~WIFE of~~) Helen Vaughan

6 DATE OF BIRTH (month, day, and year) July 1885

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	44	9 11	32 0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mc Connick

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Vaughan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Alice Pulliam

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Helen Vaughan

(Address) 1045 Woodbrights Ave

15 Filed ..... 19..... C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 1930 -192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest, au- (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

Heart

..... (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D. (Coroner)

6/4, 1930 (Address) 5632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick, Md — Date of Burial 6/6/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Cor.—12-9-25—A Co.—200 Bks.—Use typewriter in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

57777

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 E 57777

1-PLACE OF DEATH St Agnes Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 700-69 ST., WARD)

2-FULL NAME Mrs. Annie Hacker

(a) RESIDENCE NO. 2554 Holland St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Dec. 20 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER August Hacker

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Knapp

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs Carrie Shepperd
(Address) 2554 Holland St

15 Filed JUN 5 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/4/1930

17 I HEREBY CERTIFY, That I attended deceased from 6-2 ,1930 to 6-4 30 19 ,
that I last saw h.W alive on 6-4-30, 19 ,
and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Septumal appendix
Hemorrhoidal Pulmonitis

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 6-2-30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Holmes S Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 6/7/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57778

CERTIFICATE OF DEATH

1871 E 57778

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hosp. St. 27-55 Ward)

2-FULL NAME Francis McCafferty

(a) RESIDENCE NO. 5-227 Linden Heights ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): ~~Married~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 17-1900

7 AGE: Years 31 | Months 5 | Days 17 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Truck Driver
(b) General nature of industry, business, or establishment in which employed (or employer): Baltimore
(c) Name of employer: Baltimore Contracting Co

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md

PARENTS

10 NAME OF FATHER: Francis McCafferty

11 BIRTHPLACE OF FATHER (city or town): Balt
(State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Simpson

13 BIRTHPLACE OF MOTHER (city or town): Baltimore
(State or country): Md

14 Informant: Mrs. Mary McCafferty
(Address): 5227 Linden Ht. Ave

15 Filed ..... 19 ..... Registrar .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5-30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

~~Endocarditis~~ Streptococcic Infection
Duodenal Ulcer Perforating & Ulcer
Colon Duodenal
Ab 2 wks (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hodgkin's Disease
(duration) Over yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. A. Kelly Cunn, M. D.

April 5, 1930 (Address) 1699 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: April 7 1930

20 UNDERTAKER: George W Zickler — ADDRESS: 1737 Eutaw Pl.

tion should be carefully supplied. AGE should be stated EXACTLY: PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

S-1230

Spec.—2-29-28—L. F. S.—500 Bks.

E 57779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

12 9 ✓ E 57779

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 730 Pierce ST. 17-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Webb

(a) RESIDENCE NO. 730 Pierce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Louzon Webb

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Victor Billups

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Maggie Billups

(Address) 730 Pierce St

Filed JUN 5 - 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1930, to June 2, 1930, that I last saw h[illegible] alive on June 2, 1930, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Carter, M. D.

, 19 (Address) 730 Pierce

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn St	June 5 1930
20 UNDERTAKER	ADDRESS
S E Brown & Son	1014 W. Mulberry

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Cor.—10-10-29—A Co.—100 Bks.

E 57780

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

19 30 E 57780

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 4 1 Ward)

2-FULL NAME Ida Meekins

(a) RESIDENCE NO. 732 Waeche St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Aaron Meekins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Carrie Spicer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mr. Wm. Meekins
(Address) 2602 Hollinsteeray Rd.

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis due to bullet wound of abdomen. Homicide. Shot ? revolver.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 732 Waeche St.

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Dr. Grace Zellers, M. D.

6/4. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	June 5 1930
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	108 E Main

Pier No 1 Pratt St B. & O. Line

(Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

1-30—M & T—100 B—50L

E 57781

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57781

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hosp (ST.) 3-4 (WARD)

REGISTERED NO. 188-103

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME David Steinberg

(a) RESIDENCE NO 13 S Eden St (ST.) (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Steinberg

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jos Steinberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs S Steinberg

(Address) 13 S. Eden St

15 Filed ... 1930 HAMPSON JONES, M. D. Registrar

per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck + knocked down while crossing street at the intersection

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Struck + skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Central Ave + Balto

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J Paine M. D.

6/4 1930 (Address) 2939 W Eden (Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Howard Run

DATE OF BURIAL 6/5 1930

20 UNDERTAKER Sol Levinson + Bro

ADDRESS 1127 E Balto st

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very important. If deceased was housewife, so state. If wife of laborer, so state. Do not use the word "laborer" alone. Such terms may be properly classified.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 ✓

E 57782

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3823 Roland Ave (ST.) (WARD) 43-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella C. Bull

(a) RESIDENCE NO. 3823 Roland Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leonard F Bull

6 DATE OF BIRTH (month, day, and year): Feb 14 - 1871

7 AGE: Years 59 | Months 3 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: William Wooden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md

12 MAIDEN NAME OF MOTHER: Elizabeth Cross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant: Leonard Bull Jr.

(Address) 3823 Roland Ave

15 Filed JUN 5 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June - 4 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov-14-, 1929, to June 4, 1930, that I last saw her alive on June 4, 1930 and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary): Edema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) E. Gill Hall, M. D.

June 5. 1930 (Address) 1631 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: June 6 1930

20 UNDERTAKER: H.S. Marshall — ADDRESS: 35 Falls Rd

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 57783

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2601 Eastern Ave ST 1-3 WARD)

2-FULL NAME John G. Tribuld

(a) RESIDENCE NO. 2601 Eastern Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle Mount Tribuld

6 DATE OF DATE OF BIRTH (month, day, and year) Oct 27, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Technical Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Gustav Tribuld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Dietmyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Myrtle Tribuld

(Address) 2601 Eastern Ave (Woman)

Filed JUN 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3/1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1-30, 19..., to June 3/30, that I last saw h... alive on June 1-30, and that death occurred, on the date stated above, at 8 45 a m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) 1. B Laryngitis

(duration) 2 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Hermann M. D.

6/4/30 (Address) 7913 E Balto Co

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL June 7 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Bleam

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 37199
E 57784

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 ✓ E 57784

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.) 18-10 (Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Corporal

(a) RESIDENCE NO. 1004 Brantley ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	Unknown

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Wm Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Carrie Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 5 1930 JOHNS HOPKINS HOSP. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June - 2 - 1930

17 I HEREBY CERTIFY, That I attended deceased from May - 20, 1930, to June 2, 1930, that I last saw her alive on June 2, 1930, and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Generalized peritonitis.

(duration) from 4 weeks or

CONTRIBUTORY (Secondary): Postoperative shock

(duration) 8 hours

18 Where was disease contracted if not at place of death? New York

Did an operation precede death? Yes Date of June 2, 1930

Was there an autopsy? Yes No. H-11450

What test confirmed diagnosis? Clinical Autopsy

(Signed) Raymond V. Jones, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: May 5, 1930

20 UNDERTAKER: Mrs R. G. Elliott — ADDRESS: 1715 Ashland Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—2-29-28—L. F. S.—500 Bka.

E 57785 HEALTH DEPARTMENT—CITY OF BALTIMORE 9102 E 57785

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 107 E Cross ST. 24-33 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James B Douglass

(a) RESIDENCE NO. 107 E Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 14 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	1	20 19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westmoreland Co Va

PARENTS

10 NAME OF FATHER Samuel Douglass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Brinam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Sarah E Jones

(Address) 107 E Cross St

15 Filed JUN 5 - 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 14th, 1929, to June 3rd, 1930, that I last saw him alive on June 3rd, 1930 and that death occurred, on the date stated above, at 8 20 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Buxton, M. D.

6/4/1930 (Address) 301 E Cross

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL June 5 1930

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

Important. See instructions on back of certificates. Every statement of OCCUPATION is very

Cor.—10-10-29—A Co.—100 Bks.

E 57786

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 57786

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1114 N. Calhoun St. 16-22 Ward)

2-FULL NAME Virgie Roy Stockton

(a) RESIDENCE NO. 1114 N. Calhoun St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX [redacted]

4 Color or Race Col

5 Single, Married, Widowed or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct 20-1922

7 AGE Years 7 Months 6 Days 14 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Samuel Stockton

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Lettie Akers.

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Lettie Stockton
(Address) 1114 N. Calhoun

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [redacted], M. D.

June 3rd 19 , (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockamount Va

DATE OF BURIAL 6-5th 1930

UNDERTAKER Chas Katie R. Williams

ADDRESS 1122 N. Schroeder

Rev Jas. M. Skinner

Do not should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57787

CERTIFICATE OF DEATH.

90 ✓ E 57787

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 7-13 WARD)

2-FULL NAME Adolph Rasch

(a) RESIDENCE NO. 920 N. Duncan St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1846 ~~Mar~~ 4

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	~~84~~ ?	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Rasch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-3-30

17 I HEREBY CERTIFY, That I attended deceased from 9-28-29, 19..., to 6-3-30, 19...,

that I last saw him alive on 6-3-30, 19...,

and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute.

More than (duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) UNKNOWN. yrs. mos. da.

18 Where was disease contracted if not at place of death? Hour

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Paul Padget, M. D.

6-4, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem DATE OF BURIAL June 6 1930

20 UNDERTAKER Phillip Herring ADDRESS 2016 Orleans St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec. 6-9-19—H. P. Co.—1000 Bks.

E 57788 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 46E 57788

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3654 Old York Rd. (Ward) 47-44

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie V. Parks

(a) RESIDENCE. No. 3654 Old York Rd. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of Clarence E. Parks

6 DATE OF BIRTH (month, day, and year) June 5 1872

7 AGE: Years 57 | Months 11 | Days 30 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Sears

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Amanda Sandgren

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Clarence Parks (Address) 3654 Old York Rd.

15 Filed . 19 G. HAMPSON JONES, M. Registrar

By Rex.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, to June 4, 30.

that I last saw h~~e~~ alive on June 4, 30.

and that death occurred, on the date stated above, at 9:30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. L. Curtis, M. D.

6/5/30 (Address) 820 St. Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Mem

DATE OF BURIAL: June 7 1930

20 UNDERTAKER: H M Routson

ADDRESS 223 E North

JUN 5 - 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57789

HEALTH DEPARTMENT—CITY OF BALTIMORE

162

E 57789

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 621 S. Decker Ave ST. 1-2 WARD)

2—FULL NAME Chas. F. Ross

(a) RESIDENCE NO. 621 S. Decker Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Chas. F. Ross

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) M. D.

12 MAIDEN NAME OF MOTHER Ethel V. Ross

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Charles F. Ross (Father)
(Address) 621 S. Decker Ave

15 Filed JUN 5 - 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 3 1930 to June 4 1930

that I last saw him alive on June 4 1930

and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

a Acute toxemia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William R. Sauer M. D.

, 19 (Address) 801 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	June 6. 1930
20 UNDERTAKER	ADDRESS
H. Sander Sons Inc	1710 Eutaw Pl

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57790

CERTIFICATE OF DEATH.

90 E 57790

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) St. 10-14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Horgan

(a) RESIDENCE NO. 935 E. Chase St ST., City WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer) 066

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Dennis Horgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Naughton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Richard A. Horgan (Address) 935 E. Chase St

15 Filed 5 1930 .19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-5- .19 30, to 6-5- .19 30, that I last saw him alive on 6-5-30 .19 ....., and that death occurred, on the date stated above, at 2:15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Ernest Spencer Jr. M. D.

.19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 6/7 1930

20 UNDERTAKER Chas P. Graul Son — ADDRESS N. Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 57791 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 57791

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Provident Hospital 6-6 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. WARD)

2-FULL NAME Maggie R Keys

(a) RESIDENCE NO. 621 N. Schroeder ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Noble A Keys

6 DATE OF BIRTH (month, day, and year): July 16 1877

7 AGE: Years 53 (52) | Months 10 | Days 18 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co Md

12 MAIDEN NAME OF MOTHER: Mary Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mary Fisher

(Address): 1327 Argyle Ave

Filed JUN 5 - 1930 C. HALSEY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-4-30

17 I HEREBY CERTIFY, That I attended deceased from 5-1-30, to 6-4-30;

that I last saw her alive on 6-4-30,

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Hypertension

Cardio-Renal Disease

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M B Butler, M. D.

, 19 (Address) 425 N. Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 6/8 1930

UNDERTAKER: Frank Hawkins — ADDRESS: 718 N Eutaw

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA

Cor.—10-10-29—A Co.—100 Bks.

E 57792

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57792.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) En route to University St. Hospital

2-FULL NAME Frank Hochedez

(a) RESIDENCE NO. 640 W. Franklin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22 - 1876

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53	11	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Franz Hochedez

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Burgold

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Mr. Paul Hochedez
(Address) 1211 W. Balto. St.

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

6/4. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 5 1930
UNDERTAKER Wm J. Tuckner & Son	ADDRESS N. Y. Ave.

JUN 5 - 1930 BALTIMORE

Registrar

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57793

CERTIFICATE OF DEATH.

3/ ✓ E 57793

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (No. ..... St. 11-24 Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jackson

(a) RESIDENCE NO. 1300 Rutter st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 26, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 01°

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) Wilmington
(State or country) Delaware

12 MAIDEN NAME OF MOTHER Elizabeth Addison

13 BIRTHPLACE OF MOTHER (city or town) Chester
(State or country) Pennsylvania

14 Informant Hospital Records
(Address) UNIVERSITY OF MARYLAND

15 Filed JUN 5 - 1930 Name [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to June 1, 1930,

that I last saw him alive on June 1, 1930,

and that death occurred, on the date stated above, at 7.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Glennon Jr. M.D.

6-2-1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL ... 19

20 UNDERTAKER Commissioner Health

ADDRESS JUN 5 - 1930

This is very important. See instructions on back of certificates. Exact statement of OCCUPA

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57794 31 E 57794

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 76 ST. 37 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Mills

(a) RESIDENCE NO. Non-resident ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 15, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mess boy

(b) General nature of industry, business, or establishment in which employed (or employer) Freighter

(c) Name of employer Bull Line S.S. Co.

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER William Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Rosie Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

Filed JUN 5 - 1930 HARRY JONES, M.D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1930

17

I HEREBY CERTIFY, That I attended deceased from April 29, 19 30, to June 1, 19 30,

that I last saw him alive on June1, 19 30,

and that death occurred, on the date stated above, at 6.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Leo Gherardi M. D.

6-2, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

UNDERTAKER Commissioner Health

ADDRESS JUN 5 - 1930

For Wm. A. Koral

FRONT Very important. See instructions on back of certificates. EACH statement of OCCUPA-

Spec.—1-30—M. & T.—250 Blks.

E 57795 HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 57795

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T. B.)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4-7 ST. WARD)

2-FULL NAME Alex Serdes

(a) RESIDENCE NO. 797 W. Saratoga st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Theodore Serdes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Caroline Brun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Hospital Records

(Address)

15 Filed JUN 5 - 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1930

17

I HEREBY CERTIFY, That I attended deceased from June 6, 1929, to June 1, 1930, that I last saw h... alive on June 1, 1930, and that death occurred, on the date stated above, at 6.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D.

6-2-1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS JUN 5 - 1930

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-12-23—M&T—500 Blks.

E 57796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 E 57796

1-PLACE OF DEATH West Balto Gen Hosp

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto Md ST. 4-76 WARD)

2-FULL NAME Willie Johnson

(a) RESIDENCE NO. 767 Saratoga ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Willie Johnson

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N C

PARENTS

10 NAME OF FATHER Stepney Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) 767 Saratoga

15 Filed JUN 5 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1930

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 4, 1930, that I last saw him alive on June 4, 1930, and that death occurred, on the date stated above, at 5-20 A m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia Right Lung abscess

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 6-3-30

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) J. A. Blessi, M. D.

, 19 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS JUN 5 - 1930

Dep. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57797

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 57797

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospls

CITY OF BALTIMORE: (No.) Balto Md ST. 14-20 (AVE.)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Bond

(a) RESIDENCE NO. 1920 Druid Hill Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16 - 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 23

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Bond

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Phillis Harris

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Record Balt City Hospls
(Address)

Filed NOV 5 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-4-30

17 I HEREBY CERTIFY, That I attended deceased from 2-9-, 1920, to 6-4, 1930, that I last saw him alive on 6-4, 1930, and that death occurred, on the date stated above, at 4 10 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical and Clinical

(Signed) Harry H. Brown M. D.

6/5, 1930 (Address) Baltimore City Hospls.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 6-6 1930

20 UNDERTAKER Wm. H. Chase & Son

ADDRESS 1400 Madison

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA

Spec.—1-12-23—M&T—500 Blks.

E 57798

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 57798

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2821 Lake ave ST. 7-43 WARD

2-FULL NAME John. J. Bunker

(a) RESIDENCE NO. 2821 Lake ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 ~~Single~~, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Late Elizabeth Bunker

6 DATE OF BIRTH (month, day, and year) July 16 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret A. Hanson

(Address) 2821 Lake ave

15 Filed 1930 RPK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 14 1929 to June 4 1930

that I last saw h[illegible] alive on June 4 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Embolus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nathaniel Gart- M. D.

19 (Address) 2101 Gwynns Falls Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL June 7 1930

20 UNDERTAKER Ralph S. Tenner ADDRESS 147 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57799 E 57799 129

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 Chauncy Ave., St. 13-59 Ward)

2-FULL NAME Minna Fins

(a) RESIDENCE NO. 814 Chauncy Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Israel Fins

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 031

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Rascusin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Leah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant ... Lewis
(Address) 1439 E. Balto St

15 Filed ... 19 ... Registrar

C. HAWKINS, C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5-1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1925, to June 4, 1930, that I last saw her alive on ..., 1930, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Cardio Renal vascular disease

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of ...

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) A. G. Freedman, M.D.

6/5, 1930 (Address) 918 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew Cemetary — DATE OF BURIAL 6-5-1930

20 UNDERTAKER Jack Lewis 1439 — ADDRESS E Balto.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA... may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57800

CERTIFICATE OF DEATH.

E 57800

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W. North Ave. (Str.) 1561 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Martin.

(a) RESIDENCE No. 3704 Springdale Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed (Edie Simon)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband of Mrs. Chas. Martin

6 DATE OF BIRTH (month, day, and year): Dec. 30, 1876

7 AGE: Years 53 Months 5 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Commercial Printing

(b) General nature of industry, business, or establishment in which employed (or employer): Printing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Easton, Md.

PARENTS

10 NAME OF FATHER: Chas. H. Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Susie Banning

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Hospital Records

15 Filed JUN 5 1930 C. HAMDEN JONES, M. D. Registrar

Per RAM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/4/30 19

17 I HEREBY CERTIFY, That I attended deceased from 5/26/30 19 ..... to 6/4/30 19 .....

that I last saw him alive on 6/4/30 19 ..... and that death occurred, on the date stated above, at 3.25 A m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

(Ruptured)

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Fecal peritonitis

(duration) ..... yrs. ..... mos. 9 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 5/26/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A. Crupper M. D.

(Address) 1 W Gittings

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: 6/6 1930

20 UNDERTAKER: Henry U. Mears & Son

ADDRESS: 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Blks.

(Chiarmonti) (Annie Herman)

E 57801

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57801

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 210 No Rose st ST. 6-10 WARD)

2-FULL NAME Sebastiana Chiarmonti (Annie Herman)

(a) RESIDENCE NO. 210 No Rose st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~6~~ yrs. ~~mos.~~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Joseph Chiarmonti

6 DATE OF BIRTH (month, day, and year): Feb 6 1868

7 AGE: Years 62 Months 3 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Joseph Micci

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Mary Pastorini

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Sam Baglioni

(Address) 210 N. Rose st

15 Filed ..... 19 ..... Registrar

5 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3 1930

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1930, to June 3, 1930, that I last saw h~~e~~ alive on June 2, 1930, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Joseph L. Valentine M. D.

June 5, 1930 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: June 6 1930

20 UNDERTAKER: Frank V. Fiferlone — ADDRESS 2818 E. Baltimore

Spec.—1-30—M. & T.—250 Blks.

23 6996
E 57802

HEALTH DEPARTMENT—CITY OF BALTIMORE

60 E 57802

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-10 WARD)

2-FULL NAME Emma Keller

(a) RESIDENCE NO. 2704 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced, ~~HUSBAND of~~ or) WIFE of William Keller

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER George Finnegan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Buchanan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records — (Address) JOHNS HOPKINS HOSPITAL

15 Filed May 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4-30

17

I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to June 4, 1930, that I last saw her alive on June 4, 1930, and that death occurred, on the date stated above, at 4 25 P m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre

(duration) yrs. 2 mos , ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/2/30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) George E. Finney, M. D.

6/4/30 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL June 7 1930

20 UNDERTAKER J. J. Moran

ADDRESS 3000 E Balto.

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. Terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

E 57803

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57803

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6211 Belair Rd., Raspeburg ST. 26th WARD

2-FULL NAME Clara Bell Goldsboro

(a) RESIDENCE No. 6211 Belair Rd., Raspeburg. Md. ST., 26th WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Lloyd M. Goldsboro

6 DATE OF BIRTH (month, day, and year) December 3, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home (37)

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore County
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Knopp

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Sanders

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Mrs. Clara Hoffman
(Address) 5820 Belair Rd., Raspeburg, Md.

15 C. HAMPSON JONES, M. D.
June 6, 1930 AKH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1930

17

I HEREBY CERTIFY, That I attended deceased from October, 1925, to June 5th, 1930,

that I last saw her alive on June 5th, 1930,

and that death occurred, on the date stated above, at 1:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis; cardiac hypertrophy; arterio-sclerosis with hypertension.

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) A. L. Wilkinson M. D.
A. L. Wilkinson,
6/5, 1930 (Address) 5713 Belair Rd., Raspeburg, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL June 8 1930

20 UNDERTAKER George W. Zirkler — ADDRESS 1737 E. Eager st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

5 - 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 57804 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ E 57804

31

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 Pierce ST. 17-76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella G. Brown

(a) RESIDENCE NO. 724 Pierce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Ambrose Brown

6 DATE OF BIRTH (month, day, and year) Oct 4 - 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Balto City (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Ella Graves

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Ambrose Brown (Address) 724 Pierce

15 6 - 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 - 1930

17

I HEREBY CERTIFY, That I attended deceased from Apr. 10 -, 1930, to June 4, 1930, that I last saw h e alive on June 4, 1930 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) indefinite yrs. mos. da.

CONTRIBUTORY (Secondary) Acute bronchitis

(duration) — yrs. — mos. 21 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Chas. J Keller, M. D.

6/5, 1930 (Address) 2226 W Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	6/7/1930
20 UNDERTAKER	ADDRESS
Geo. H. Holland	163 Druid Hill Ave

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Colored 672

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57805

E 57805

1929

X 46 F 67

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Fenhorn Memorial Hospital

CITY OF BALTIMORE: (No.) 1000 Caton Ave ST. 25-11 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Weidkie

(a) RESIDENCE No. Dunmore Lane ST., Catonsville Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. H. Weidkie

6 DATE OF BIRTH (month, day, and year) Dec 26th 67

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	5 4	9 8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) =

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Burke

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Estelle Becker

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Fenhorn Memorial Hosp.
(Address)

15 Filed June 6 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1930

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 4, 1930, that I last saw h[illegible] alive on 6-4, 1930, and that death occurred, on the date stated above, at 12-45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of body of uterus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	6/6/1930
20 UNDERTAKER	ADDRESS
H. B. Nusbaum	150 N. Gallo St.

TION is very important See instructions on back of certificates. so that it may be properly classified. Exact statement of OCC

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 57806

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 Fonthill Av ST., 20-20 WARD)

2-FULL NAME Mena J. Kellner

(a) RESIDENCE NO. 411 Fonthill Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of John C. Kellner

6 DATE OF BIRTH (month, day, and year) Jan 28th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Chr Theumann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gunderman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna L. Foos

(Address) 411 Fonthill Av

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4/30

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1930, to June 4, 1930,

that I last saw her alive on June 4, 1930,

and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Findings

(Signed) Wittenberg Fort M. D.

6/6, 1930 (Address) 20 E. Preston St. Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 6th 1930
20 UNDERTAKER	ADDRESS
A B Wagner	1502 N. Gilmor St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 35747
E 57807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122-902
E 57807

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Mauzy

(a) RESIDENCE NO. Franklin W. Va ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Leila

6 DATE OF BIRTH (month, day, and year) Oct 25-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W Va

PARENTS

10 NAME OF FATHER James Mauzy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Malinda Phares

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-5-1930

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1930, to June 5, 1930, that I last saw him alive on June 5, 1930, and that death occurred, on the date stated above, at 6.45 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Hypertension, Myocardial Insufficiency, Chronic Nephritis, Uremia, yrs. Contributory (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) James Bordley III, M. D.

6-5, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Franklin Cemetery W Va — DATE OF BURIAL June 6-1930

20 UNDERTAKER Fortney Gore — ADDRESS 123 W Lafayette Ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

Dr. Billups 2224 W. North Ave

E 57808

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 57808

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2345 W. North Ave St.) 15-68 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Ford

(a) RESIDENCE No. 2345 W. North Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND ~~of~~ (or) WIFE of Thomas W. Ford

6 DATE OF BIRTH (month, day, and year) July 31st 1853

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
76	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Benjamin Lee

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Robert Ford

(Address) 2345 W North Ave

15 Filed 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 5- 1930, to June 5- 1930, that I last saw h~~e~~r alive on June 4 1930, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys Examination - Urinary Tract

(Signed) G W Billups, M. D.

, 19 (Address) 2224 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 6/7/1930

20 UNDERTAKER Wm Cook 1217

ADDRESS St Paul

TION is very important. See instructions on back of certificates. Exact statements of OCC... ...ames, so that it may be properly classified.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57809

CERTIFICATE OF DEATH

46 E 57809

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3609 Green Spring Av. (St.:) 13-57 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katherine A. Leckner

(a) RESIDENCE NO. 3609 Green Spring Av. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Leckner

6 DATE OF BIRTH (month, day, and year): Sept. 8 / 1862

7 AGE: Years 68 Months ~~7~~ 2 Days —

IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Bernard Ward

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Dunn

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland

14 Informant: Mrs Kath. A. Leckner

(Address): 406 Fleetwood Av.

15 Filed JUN 6 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 / 30 19

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1922 to June 5th 1930, that I last saw her alive on June 5th 1930, and that death occurred, on the date stated above, at 5.00 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes, followed by Bright's Dis. and Malignant Cancer of Uterus (Carcinoma)

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage from Uterus

(duration) 12 hrs. yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) E. Schmidt, M. D.

6/5, 1930 (Address) 605 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

Date of Burial: 6/9/1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul St

Use pencil or carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

57810

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001
E 57810

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 4-30 Ward)

2-FULL NAME John Puffer

(a) RESIDENCE NO. 613 W. Redwood St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jeanette Puffer

6 DATE OF BIRTH (month, day, and year) about 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Ot
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Mich.

PARENTS

10 NAME OF FATHER Chas. Puffer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. Y.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown.

14 Informant Catherine Puffer
(Address) 2680 Heath Ave New York N. Y.

15 Filed ..., 19.. C. HAMPSON JONES M. D. Registrar

Ref

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Fellers, M. D.

6/5. 1930. (Address) 239 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden Cemetery	6/6/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul st

IMPORTANT. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

...should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE ...ATISTICAL RECORD. Every item of informa-

Spec.—2-29-28—L. F. S.—500 Blks.

E 57811

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

E 57811

CERTIFICATE OF DEATH

1—PLACE OF DEATH Hospital for the Women of Maryland — REGISTERED NO.

CITY OF BALTIMORE: (No. Lafayette and John ST., 28-77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sara Virginia Kellinger (Mrs.)

(a) RESIDENCE NO. 5109 Edmondson Avenue. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 6 mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Albert Kellinger

6 DATE OF BIRTH (month, day, and year) November 14, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	72	6	21	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Maryland
(State or country)

PARENTS

10 NAME OF FATHER Mordecai Gist Hussey

11 BIRTHPLACE OF FATHER (city or town) Mitchell
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ellen Hanaee

13 BIRTHPLACE OF MOTHER (city or town) New Windsor
(State or country) Maryland

14 Informant Esther Virt Hall (Mrs.) Sister
(Address) 5109 Edmondson Avenue

15 Filed JUN 6 - 1930 BUREAU OF VITAL STATISTICS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 4, 1930, that I last saw h.e.r alive on June 4, 1930 and that death occurred, on the date stated above, at 5.12 P. m.

The CAUSE OF DEATH* was as follows:

Cardio vascular renal disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. G. Hardyce, M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 7 1930
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St.

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—1-30—M. & T.—250 Blks

E 57812 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 E 57812

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 S. Bouldin St. 26-7 Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carolin Tauber

(a) RESIDENCE NO. 227 S. Bouldin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Tauber

6 DATE OF BIRTH (month, day, and year) Feb 12, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Jennie Kestner
(Address) 227 Bouldin

15 Filed JUN 6 - 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 6, 1930, that I last saw her alive on June 5, 1930, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

6

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Litsow, M. D.

6/6, 1930 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	June 1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-30—M. & T.—300 blks.

237459

E 57813

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 57813

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 12-51 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Heberle

(a) RESIDENCE NO. 2603 Bernard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Nov-19-1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18.	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer at home.

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER John L. Heberle.

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Minnie Cooper

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

Filed JUN 6 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-4-1930

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1930, to June 4, 1930, that I last saw her alive on June 4, 1930, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uremia

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uremia.

(Signed) James Bordley, M. D.

6-5, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Co. Maryland — DATE OF BURIAL 6/7/30

20 UNDERTAKER J. Walter Davis — ADDRESS 3307 Paine St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

57814

HEALTH DEPARTMENT—CITY OF BALTIMORE

1944 E 57814

CERTIFICATE OF DEATH

1-PLACE OF DEATH Re street and Curtis Bay

City of Baltimore: (No. Fairfield - Md. St., 3-5 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sidor Protzuik (Samuel Brasik)

(a) RESIDENCE NO. 1157 E. Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. —mos. ds. How long in U. S., If of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) no 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Md. Drydock Co.

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER no

11 BIRTHPLACE OF FATHER (city or town)
(State or country) no

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) no
(State or country)

14 Informant Mary Dawtuk
(Address) 631 ann Donaldson

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Exhaustion

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D.

6/6, 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russian Jewish Cemetery	June 6 1930
20 UNDERTAKER	ADDRESS
John Gudelianas	423 S. Paca St.

JUN 6 1930

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 57815

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 57815

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST 16-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgia Jennings

(a) RESIDENCE NO. 1137 N. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Thomas Jennings

6 DATE OF BIRTH (month, day, and year) Sept 29 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md West River.

PARENTS

10 NAME OF FATHER Wesley Starks

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Mattie Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mabel Robertson.

(Address) 1120 Woodyear St

15 Filed 19 G. HAMPSON JONES, M. D. Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1930

17

I HEREBY CERTIFY, That I attended deceased from May 31, 1930, to June 2, 1930, that I last saw h alive on June 2, 1930, and that death occurred, on the date stated above, at 6 ~~A~~ P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Hypertension Cardio vascular

(duration) about ~ mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Ronald M Stelan, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 6/0 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Presstman St

IMPORTANT is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Cor.—10-10-29—A Co.—100 Bks.

E 57816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

5 4 ✓ E 57816

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 19-27 Ward)

2-FULL NAME Wm. S. Thomas

(a) RESIDENCE NO. 1610 N Franklin St., Ward

(Usual place of abode) Life (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 31 1890

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40		2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md.

PARENTS

10 NAME OF FATHER Samuel Thomas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) md.

12 MAIDEN NAME OF MOTHER Julia Peele

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) md.

14 Informant Randolph Thomas.
(Address) 1610 W Franklin St

15 Filed ... 19... C. HAMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) ... 3 192...

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cellagra.

6 yrs. (duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Ex Laundress

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Southern

Did an operation precede death? — Date of —

Was there an autopsy? Jail

What test confirmed diagnosis? Physical Findings

(Signed) G C Blades, M. D.

, 19 (Address) 1436 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	6/6 1930
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1303 Prestman's

Rev

Now among the carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57817

100-001

CERTIFICATE OF DEATH

E 57817

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hosp. St., 49-27 Ward)

2-FULL NAME Lula May Taylor

(a) RESIDENCE NO. 22 N. Mon St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 19 1930

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
		7	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto —
(State or country)

PARENTS

10 NAME OF FATHER Nathaniel Taylor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Hattie Taylor

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Hattie Taylor
(Address) 22 N. Mon St.

15 Filed JUN 9 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1930

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Primary) (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. F. Brooke, M. D.

6/5, 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dist Auburn Cem	June 7th 1930
20 UNDERTAKER A. Jones	ADDRESS 111 S. Eden

Your answers should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57818

CERTIFICATE OF DEATH.

10 E 57818

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 32 E. Hughes ST. 22-33 WARD

2-FULL NAME Clara Thomas Stewart

(a) RESIDENCE NO. 32 E Hughes ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. + mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	47	+		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer - 86

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sanjo Packing Co. Calvert Co Maryland -

9 BIRTHPLACE (city or town) (State or country) Maryland -

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Rachel Tillerson Howe De Grace -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland -

14 Informant William H. Lyon (Address) 32 E Hughes St.

15 Filed 6 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5/30

17 I HEREBY CERTIFY, That I attended deceased from 5/28, 1930, to 6/5, 1930, that I last saw h[illegible] alive on 6/4, 1930, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? None

(Signed) David Svanklin, M. D.

6/5, 1930 (Address) 122 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery

DATE OF BURIAL 6/8 1930

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1539 Eutaw St

ATION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57819

CERTIFICATE OF DEATH

129 E 57819

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3008 Benson Ave ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Henry Schillinger

(a) RESIDENCE NO. 3008 Benson Ave ST. 25 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) Elizabeth W. Schillinger

6 DATE OF BIRTH (month, day, and year) June 10, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	72	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stopper Foreman.

(b) General nature of industry, business, or establishment in which employed (or employer): Stopper Building.

(c) Name of employer: Retired City Water Department

9 BIRTHPLACE (city or town) (State or country): Baltimore City.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. John H. Schillinger

(Address) 3008 Benson Ave.

15 Filed JUN 6 1930 19 HAMILTON PHILLIPS M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1927, to June 4, 1930, that I last saw him alive on June 3, 1930 and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests.

(Signed) H. Lamont Wheeler, M. D.

6/4, 1930 (Address) 2410 Hollins Ferry Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: June 6 1930

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 West Baltimore St

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—1-30—M. & T.—250 Bks.

If possible drive not give cause of death E 57820

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 57820

CERTIFICATE OF DEATH.

3 1 V

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2935 Guilford Ave (WARD) 19-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry B. Cook

(a) RESIDENCE NO. 2935 Guilford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula H. Cook

6 DATE OF BIRTH (month, day, and year) Jan 1 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
✓	58.	6.	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mfg Agent 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Eugene Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary M. Markley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lula H. Cook (Address) 2935 Guilford Ave

15 Filed JUN 8 - 1930 H. M. JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 - 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1928, to June 5, 1930, that I last saw him alive on June 5, 1930, and that death occurred, on the date stated above, at 8.45 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. + mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory test

(Signed) Jefferson Buck M. D.

6/5, 1930 (Address) 5 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	June 7 1930
UNDERTAKER	ADDRESS
Jos. Syfer	600 W. North Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-30—M. & T.—250 Blks.

237469
E 57821

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49 ✓ E 57821

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr David Sampsell

(a) RESIDENCE No. Winfield Pa ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Emma J Sampsell

6 DATE OF BIRTH (month, day, and year) Aug 22 - 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	9	15	

8 OCCUPATION OF DESECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER George Sampsell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Catharine Catherman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

JUN 6 1930 C. HALL JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June - 6 - 1930

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1930, to June 6, 1930,

that I last saw him alive on June 6, 1930,

and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate

metastasis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray, cystoscopy

(Signed) Edward Jayne, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Lewisburg Pa.

DATE OF BURIAL 6/6 1930

20 UNDERTAKER Chas F. Grace & Son

ADDRESS 1811 W Mt Royal Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-12-23—M&T—500 Blks.

E 57822 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ E 57822

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital St. 9-16 (WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary E. Nugent

(a) RESIDENCE NO. 905 Boone ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank P. Nugent

6 DATE OF BIRTH (month, day, and year) Sept 4, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John W. Valentine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary A. McGaughan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant (Address) John S. Nugent

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 3rd, 1930, to June 4th, 1930,

that I last saw her alive on June 4th, 1930,

and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Heart Disease. Hypertensive.
With Nephritis.

Not known
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage.
(duration) ..... yrs. ..... mos. One ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Physical Signs and tests.

(Signed) Louis P. Tinsley, M. D.

June 7, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	June 7 1930
20 UNDERTAKER	ADDRESS
Rida Friedfeld	914 Greenmount Ave

NOV 6 1930 C. HAMBOURGOMIS, M.D.

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 57823 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 57823

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1715 Bond St.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1715 Bond St. 7-13 WARD)

2-FULL NAME Jane R. Cornish

(a) RESIDENCE NO. 1715 Bonner St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm D. Cornish

6 DATE OF BIRTH (month, day, and year) June 30 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer Herself.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Fannie Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Leonard Cornish

(Address) 1715 W. Barner St

Filed ..... 19 .....

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 June 30

17 I HEREBY CERTIFY, That I attended deceased from April, 1930, to 3 June, 1930, that I last saw h[illegible] alive on 3 June, 1930, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

aortic insufficiency

Heart Disease (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Sudden Heart Failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) E. Mayfield Burke M. D.

6/6/1930 (Address) 838 N. Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL June 6 1930

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1219 Ashland Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-12-23—M&T—500 Blks.

E 57824

HEALTH DEPARTMENT—CITY OF BALTIMORE

E/57824

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2912 Louisa ave. ST., 17-43 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Archer

(a) RESIDENCE NO. 2912 Louisa Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, ~~or Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie V. Archer nee Hall

6 DATE OF BIRTH (month, day, and year): Oct. 28. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Michael J. Archer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio.

12 MAIDEN NAME OF MOTHER: Susanna Dinges

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Nellie Virginia Archer

(Address): 2912 Louisa Ave.

15 Filed 6 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/4/30 19

17

I HEREBY CERTIFY, That I attended deceased from January 31. 1930, to June 4. 1930.

that I last saw h. live on June 4 1930

and that death occurred, on the date stated above, at 330 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert Schaefer M. D.

6/5. 1930 (Address) 2025 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem.

DATE OF BURIAL: 6/7/30 19

20 UNDERTAKER: Geo. Lintach

ADDRESS: 525 N. Lyndhurst

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

237294
E 57825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 38 E 57825

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Johnson

(a) RESIDENCE No. Cambridge Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male | 4 COLOR OR RACE Black | 5 Single, Married, Widowed, or Divorced, (write the word) M

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec-10-1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanical Work

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... C. HAMBLETON JONES, M. D. Registrar

UN 6 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-4-1930

17

I HEREBY CERTIFY, That I attended deceased from May 23, 1930, to June 4, 1930, that I last saw him alive on June 4, 1930, and that death occurred, on the date stated above, at 6 30 p. m.

The CAUSE OF DEATH* was as follows:

Aortic aneurysm.

Symptom (duration) yrs. 8 mos ..... ds.

CONTRIBUTORY (Secondary) Perforation & Hemorrhage (duration) yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes. Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Xray & Thoracentesis

(Signed) I. Rodriguez M. D.

June 6 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL 6/6 1930

20 UNDERTAKER Samuel T. Kemsley

ADDRESS Cambridge Md

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-30—M. & T.—250 Blks.

E 57826

E 57826 HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 57826

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS 7-12

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ——— ST., ——— WARD)

2-FULL NAME Albert J. Kvet

(a) RESIDENCE NO. 908 N. Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary Kvet.

6 DATE OF BIRTH (month, day, and year) March 3, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass Molder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Kvet.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Elizabeth Bolek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Record of (Address) BALTIMORE CITY HOSPITALS

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1930

17

I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to June 5, 1930, that I last saw h alive on June 5, 1930, and that death occurred, on the date stated above, at 9:50 A.m.

The CAUSE OF DEATH* was as follows:

Syphilis of Aorta with aortic insufficiency.

(duration) more than yrs. 18 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

Gauses (duration) More than yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Paget, M. D.

6-5-1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL June 9 1930

20 UNDERTAKER Frank Brach & Son 1906 — ADDRESS Carlton Av

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57827

CERTIFICATE OF DEATH

90 ✓ E 57827

1-PLACE OF DEATH

City of Baltimore: (No. 2330 E. Balto. St., 6-10 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tobie Levinson

(a) RESIDENCE NO. 2330 E. Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jos. Levinson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

037

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant A. Levinson (Son)
(Address) 2562 W. Balto. St.,

Filed JN 6 - 1930 19 R.L.L. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 - 192 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. H. Kallen, M. D.

6/6 1930 (Address) 508 E. North Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 6-7 19

20 UNDERTAKER Jack Levin, 1439

ADDRESS E. Balto St.

IMPORTANT.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57828 pronounced dead — + 196 — E 57828

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH University Hospital

City of Baltimore: (No. New Freedom, Md St. 4-30 Ward)

2-FULL NAME Frank Millers

(a) RESIDENCE NO. Catonsville, Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alma Millers

6 DATE OF BIRTH (month, day, and year) Sept. 21-1905

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	24	8	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Line man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Co. Gas E.L.&P. Co.

9 BIRTHPLACE (city or town) _____
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) —

14 Informant Alma Miller
(Address) 3141 Kentucky Ave

15 Filed 6-1930, 19 ____ Registrar RMH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electrocuted. Accidental Death.
While at work on pole -
Came in contact w/ live wire.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) _____

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) Eugene Millers, M. D.

6/4, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rood - June 7-30

DATE OF BURIAL 19

20 UNDERTAKER J. Wm. Dexter & Son 3001 Kentucky

ADDRESS

IMPORTANT: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 57829

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57829

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 838 Hamilton Terrace ST., 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Small

(a) RESIDENCE NO. 838 Hamilton Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John 1864

6 DATE OF BIRTH (month, day, and year) May 20 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66 74	—	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Columbia S.C.

PARENTS

10 NAME OF FATHER Jno. Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose Brander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Rose Fogley

(Address) 2647 Loyola Southway

UN 6 - 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1930

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1930, to June 6, 1930, that I last saw h alive on June 5 1930, and that death occurred, on the date stated above, 9:20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Aortic insufficiency

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pillsbury, M. D.

, 19 (Address) 617 Hamilton Terrace

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL June 9 1930

20 UNDERTAKER Penny Hoech Funl. Svc. ADDRESS 1301 E Eager St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 E 57830

E 57830

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 406 S. Exeter ST., 35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Bacigalupa

(a) RESIDENCE NO. 406 S. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. (50) mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Bacigalupa

6 DATE OF BIRTH (month, day, and year) April 12, 1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
70	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Bartholomew Costa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Charles Bacigalupa

(Address) 3526 Elm Ave

15 Filed JUN 6 1930, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/4/30

17 I HEREBY CERTIFY, That I attended deceased from 6/1, 1930, to 6/4, 1930, that I last saw h[illegible] alive on 6/4, 1930, and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood pressure

(Signed) [illegible], M. D.

6/5, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 7 1930
20 UNDERTAKER	ADDRESS
Frank V. Sipitone	251 S. Eutaw St

Spec.—2-29-28—L. F. S.—500 Bks.

E 57831

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57831

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 221 President ST. 35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Marotta

(a) RESIDENCE NO. 221 President ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 24 mos. ds. How long in U. S., if foreign birth? yrs. 32 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Marotta

6 DATE OF BIRTH (month, day, and year) April 1, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) City 040

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Vincent Marotta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Coletta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mary Loccagna

(Address) 223 President

15 Filed C. NAMESON JONES, M. D. Registrar

6 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-3-30

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1929, to June 3, 1930

that I last saw him alive on June 3, 1930

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Renal disease

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Anthony L. Cittadini, M. D.

6-5, 1930 (Address) 1038 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL June 7 1930

20 UNDERTAKER Frank V. Lipitone — ADDRESS 2515 E. Baltimore St

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57832 ✓ E 57832

CERTIFICATE OF DEATH.

E 57832

1-PLACE OF DEATH Md General Hosp. 117

REGISTERED NO.

CITY OF BALTIMORE: (NO. Balto Md. ST. 15-62 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna S Weikert

(a) RESIDENCE NO. 3412 Calloway Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Weikert

6 DATE OF BIRTH (month, day, and year): July 22, 1866

7 AGE: Years 64 Months 10 Days 13 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Schubert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Reinhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. Geo. S. Weikert

(Address) 3412 Calloway Ave.

15 Filed JUN 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 5 1930

17

I HEREBY CERTIFY, That I attended deceased from June 4, 1930, to June 5, 1930, that I last saw h alive on June 5, 1930, and that death occurred, on the date stated above, at 4:20 a. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos ? ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. L. Kerpchmidt, M. D.

6/5, 1930 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemy.

DATE OF BURIAL: June 7, 1930

UNDERTAKER: John D. Mitchell & Sons

ADDRESS: 1900 Eutaw Place

Spec.—1-10-21—M&T—1500 Blks. AGE should be stated EXACTLY. PHYSICIANS should state DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 57833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 ✓ E 57833

1—PLACE OF DEATH

REGISTERED NO. 13-59

CITY OF BALTIMORE: (No. 3324 Auchentoroly Ter. ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susannah Winters Friede

(a) RESIDENCE NO. 3324 Auchentoroly Terrace ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. C. Friede

6 DATE OF BIRTH (month, day, and year) Dec. 7, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Andrew Winters

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Wilhelmina

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. Henry E. Friede

(Address) 4201 St. Paul St.

FILED JUN 6 - 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-25, 1930, to 6-5, 1930, that I last saw her alive on 6-5, 1930 and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

CARCINOMA OF RECTUM

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? YES Date of 1925

Was there an autopsy? No.

What test confirmed diagnosis? MICROSCOPIC SECTIONS

(Signed) John F. Dorsey, M. D.

, 19 (Address) 1129 St. Paul St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	June 7 1930
UNDERTAKER	ADDRESS
John A. Mitchell & Son	10 E. Eutaw Pl.

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57834

CERTIFICATE OF DEATH.

74 E 57834

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 N. Calvert St. 17-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ann La Compte

(a) RESIDENCE No. 2203 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of David LaCompte

6 DATE OF BIRTH (month, day, and year) Sept 10 1850

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	80	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Snow Hill Md

PARENTS

10 NAME OF FATHER Cary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Celia Bevans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Billy Washington (Address) Calvert Court apts

15 Filed ..... 19 ..... Registrar

H. HAMPTON JONES, M.D.

JUN - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6/30

17

I HEREBY CERTIFY, That I attended deceased from Sept, 1929, to June 6, 1930, that I last saw her alive on June 5, 1930, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) John S. Bishop, M. D.

19 (Address) 122-25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Snow Hill Md	June 7 1930
UNDERTAKER John O Mitchell & Sons	ADDRESS 19th Entaw

John O Mitchell

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57835

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 159-002 E 57835

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital St. 609 (Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Frampton

(a) RESIDENCE NO. ~~Sinai Hosp~~ Love St., Point Md Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of child

6 DATE OF BIRTH (month, day, and year) Oct 22-1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~1 month~~		7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Nathaniel Frampton

11 BIRTHPLACE OF FATHER (city or town) Orpah Pa
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Hostetter

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Elizabeth Frampton
(Address) Mother Love Pt. Baltimore Md.

15 Filed JUN 6 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1930

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to June 6, 1930,
that I last saw ~~him~~ alive on June 6, 1930,
and that death occurred, on the date stated above, at 12.15 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Suffocating Anemia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Samuel B. Hamman M.D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Love Point Md. DATE OF BURIAL June 6 1930

20 UNDERTAKER Lilly & Zeiler Inc. ADDRESS 403 S. Wolfe St

TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 57836

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

164 E 57836

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5311 Midwood Ave ST. 27-48 (WARD)

2-FULL NAME Mary Haynes

(a) RESIDENCE NO 5311 Midwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Apr 16/1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	91	1	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) New York,
(State or country) N.Y.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Joseph Benoska
(Address) 5311 Midwood Ave

15 [illegible] 1930 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] Coroner, M. D.

5/5/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Presbyterian, Govans

DATE OF BURIAL 6/7 1930

20 UNDERTAKER [illegible]

ADDRESS 1217 Pond St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

6

Spec.—1-12-29—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57837

CERTIFICATE OF DEATH.

+ 118

E 57927

1-PLACE OF DEATH West Balto Gen Hosp

CITY OF BALTIMORE: (No. Balto, Md ST. 16-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Orille Browning

(a) RESIDENCE NO. Monkton, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Ralph Browning

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Dowel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lynn F Browning

(Address) Oakland Md

15 Filed JUN 6 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1930

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 4, 1930,

that I last saw him alive on June 4, 1930,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 3 da.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 3-1930

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. V. Cologna, M. D.

, 19 (Address) W. Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL JUN 6 1930

20 UNDERTAKER Commissioner Health.

ADDRESS

Per. Wm. B. Kobell

Spec.—2-29-28—L. F. S.—500 Blks.

E 57838 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E. 57838

E [redacted]

CERTIFICATE OF DEATH 129 E. [redacted]

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1504 N. Fulton Ave. ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas E. Arnold

(a) RESIDENCE NO. 1504 N. Fulton Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugenia Arnold

6 DATE OF BIRTH (month, day, and year) May 12, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	-	24 25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) L A Co Maryland

PARENTS

10 NAME OF FATHER Elijah R. Arnold

11 BIRTHPLACE OF FATHER (city or town) A.A. County (State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda Hammond

13 BIRTHPLACE OF MOTHER (city or town) A.A. County (State or country) Maryland

14 Informant M E Arnold (Address) 1504 No Fulton Ave

15 Filed 6-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jany 5th, 1930, to date of death, 19..., that I last saw him alive on June 6th, 1930 and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Death was due to chronic myocarditis

of long duration (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Anaemia & old age

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual tests,

(Signed) Chas. Du Vare, M. D.

6/6, 1930 (Address) 824 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waugh Chapel Anne Arundel County, Md

DATE OF BURIAL June 8 1930

20 UNDERTAKER Earl B Cook

ADDRESS 1003 West Baltimore St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 57839

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57839

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

City of Baltimore: (No. 613 N. Athol St., 16-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward H. Powers

(a) RESIDENCE NO. 613 N. Athol St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edw E

6 DATE OF BIRTH (month, day, and year) Aug 24-1854

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	73	9	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Upholstering
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John H. Powers

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Emeline Laurie

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Edward H. Powers
(Address) 613 N. Athol St.

15 June 7 1930 C. HAMPSON JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ..... M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 9 1930
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	2178 Pa

6

Should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E. 57840 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 57840

154-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3405 Hamm Court St. 76-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Body (Boy) Stallings

(a) RESIDENCE NO. 3405 Hamm Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-3-30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Edward Lee

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Murphy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Ed L. Stallings
(Address) 3405 Hamm Court

15 Filed JUN 6 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6/30

17 I HEREBY CERTIFY, That I attended deceased from 6/3, 1930, to 6/6, 1930, that I last saw h[illegible] alive on 6/6, 1930, and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Congenital Malformation of Heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? clinical

(Signed) Harry Weinstock, M. D.

, 19 (Address) 1730 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL 6/7 1930

20 UNDERTAKER Frederick M. Fe — ADDRESS 1200 W Fayette

IMPORTANT. Every question must be properly answered. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57841

CERTIFICATE OF DEATH

129 E 57841

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 535 Brice ST. 20-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth C Dalleway Donohue

(a) RESIDENCE NO. 535 Brice ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 5-1848

7 AGE: Years 81 | Months 8 | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or (State or country)): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or (State or country)): Germany

14 Informant: Mrs Mary Atkinson

(Address): 535 N. Brice St

15 Filed 6 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 5- 1930

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to June 5, 1930

that I last saw h alive on June 4, 1930

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Parenchymatous Nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

6/5, 1930 Address) 1663 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters — DATE OF BURIAL: 6/7 1930

20 UNDERTAKER: Frederick A & E — ADDRESS: 208 N Howard

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

Fenby 1222 Caroline St -

E 57842

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 E 57842

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 Aisquith St. 9-18 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Fernandy Chamberlain

(a) RESIDENCE NO. 1819 Aisquith St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ivy -

6 DATE OF BIRTH (month, day, and year) Sept 15 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	72	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Montgomery & Ward

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Fernandy Chamberlain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Sarah Hastie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Mary Chamberlain

(Address) 1727 E. Chase St.

Filed JUN 5 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1930

17

I HEREBY CERTIFY, That I attended deceased from Sept. 30 - 1929, to June 6 - 1930, that I last saw him alive on May 31 - 1930, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) — yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

6/6/1930 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine June 9 1930

20 UNDERTAKER A. M. Cook ADDRESS 1217 St. Paul

TION is very important. See instructions on back of certificates. Exact statement of OCCU

Spec.—1-30—M. & T.—250 Blks

E 57843 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St. 16-26 Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernestine Ireland

(a) RESIDENCE NO. 1008 Edmondson Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 22, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Charles Ireland

11 BIRTHPLACE OF FATHER (city or town) Balto.,
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Snowden

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Charles Ireland
(Address) 1008 Edmondson Ave

15 Filed ....., 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-5-30

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1930, to June 5, 1930, that I last saw her alive on June 5, 1930 and that death occurred, on the date stated above, at 2 46 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) about yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 6-7 1930

20 UNDERTAKER David Carter

ADDRESS 516 Ba ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 57814 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57814

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 W. Lanvale St. 16-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kris William Diggs

(a) RESIDENCE NO. 1212 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Diggs

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (City or town) (State or country) Anne Arundel Co. Md

PARENTS

10 NAME OF FATHER John Diggs

11 BIRTHPLACE OF FATHER (City or town) (State or country) Anne Arundel Co. Md

12 MAIDEN NAME OF MOTHER Annie Savoy

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Anne Arundel Co. Md

14 Informant (Address) Mrs. Alverta Hutchins 1212 W. Lanvale St.

Filed JUN 7 - 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to June 4th, 1930, that I last saw him alive on June 4th, 1930, and that death occurred, on the date stated above, at 8.45 P.M. E.S.T.

The CAUSE OF DEATH* was as follows:

1. Chronic Endocarditis

(duration) yrs. 1 mos ds.

a. Chr. Myocarditis

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jas E Bell, M.D.

, 19 (Address) 1213 Division St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westlawn Cem. Balto Co. Md

DATE OF BURIAL 6-7-30

20 UNDERTAKER Robert Carter

ADDRESS 916 Dolphin St

TION is very important. See instructions on back of certificates. Exact statement of OCC

Spec.—1-30—M. & T.—250 Bks.

E 57845

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57845

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 17-24 WARD)

2-FULL NAME Leonard Frank

(a) RESIDENCE NO. 533 Camel ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) West Indies

PARENTS

10 NAME OF FATHER Hance Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies

12 MAIDEN NAME OF MOTHER Maria Cornelius

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Indies

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 7 1930, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-5-30

17 I HEREBY CERTIFY, That I attended deceased from 6-4-30, 19..., to 6-5-30, 19...,

that I last saw him alive on 6-5-30, 19...,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic, without oedema.

More than (duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Rouse

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical; lab.

(Signed) Paul Padget, ... M. D.

6-6, 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	6-7 Jun 30
UNDERTAKER	ADDRESS 916 Pa. Ave.
Daniel Carter	

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57846

CERTIFICATE OF DEATH.

31

E 57846

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 W Read St. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Roeder

(a) RESIDENCE NO. 229 W. Read ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 11th 1894

7 AGE: Years 36 Months 2 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Charles G Roeder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Gundlach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Charles G Roeder (Address) 229 W Read St

15 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/6/ 1930

17 I HEREBY CERTIFY, That I attended deceased from March, 1930, to Jun 6th, 1930, that I last saw her alive on Jun 5th, 1930, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bulbar Paralysis of Right Lung from Cheesing mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J D Lefstead M. D.

6, 1930 (Address) 711 N. Fannie

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Holy Redeemer DATE OF BURIAL: June 9 1930

20 UNDERTAKER: Henry H Jenkins Sons Co ADDRESS: Gordon Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7 - 1930

Spec.—1-30—M. & T.—250 Blks

E 57847 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57847

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2952 N. North St. 15-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie L. Williams

(a) RESIDENCE NO. 2952 N. North St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 0 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Edward A. Williams

6 DATE OF BIRTH (month, day, and year) May 9-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md

PARENTS

10 NAME OF FATHER Hugh Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore. Md

12 MAIDEN NAME OF MOTHER Emily Mathaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore. Md

14 Informant Mrs Edward A. Williams

(Address) ~~2952 N. North Ave~~

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1928, to June 4, 1930,

that I last saw h[illegible] alive on June 4, 1930,

and that death occurred, on the date stated above, at 12.05 A m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ernest H. Palmer, M. D.

6/6, 1930 (Address) 3005 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL June 7 1930

20 UNDERTAKER H. G. Tickner & Son — ADDRESS North Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57848

CERTIFICATE OF DEATH.

185 E 57848

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland Gen'l Hospital (St.) 17-50 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabelle Scott

(a) RESIDENCE NO. 327 E. Lovaine Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 85 mos. 9 ds. 4 How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe.	Cau.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Emory Scott

6 DATE OF BIRTH (month, day, and year) Aug 31, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	9	4 3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Ralph Brunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret McCann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records (Address)

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1930

17

I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to June 4, 1930, that I last saw her alive on June 4, 1930, and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Fracture of Right Femur

(duration) yrs. mos 4 weeks dys

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 3 mos. 3 days

18 Where was disease contracted if not at place of death? At home

Did operation precede death? No Date of

Was there an autopsy? No

Were findings confirmed diagnosis? Clinical.

(Signed) J. Robert Welles, M. D.

19 (Address) Md. Gen. Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	June 7 1930
20 UNDERTAKER	ADDRESS
Wm. Fleckner Sons	Morrx Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blo

E 57849

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57849

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5704 Bland Ave W. 27-55 WARD)

2-FULL NAME Edward Lee Schulte

(a) RESIDENCE No. 5704 Bland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 5 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Schulte

6 DATE OF BIRTH (month, day, and year) Jan. 5-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commercial artist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Fred. W. Schulte

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Baer

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs. Margaret Schulte (Address) 3402 Lynchester Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6-1930

17 I HEREBY CERTIFY, That I attended deceased from 6/6/30, 19..., to 6/6/30, 19..., that I last saw h[illegible] alive on 6/6/30, 19..., and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of nose & throat.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage.

(duration) yrs. mos. 1/3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical.

(Signed) J. M. Blake M.D.

6/7, 1930 (Address) 5912 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL June 9 1930

UNDERTAKER Wm. J. Tickner Sons — ADDRESS N. Y. Ave

TION is very important. See instructions on back of certificates. Exact statement of OCC[illegible]

Cor.—10-10-29—A Co.—100 Bks.

E 57850

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-1001

E 57850

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St 12-19 Ward)

2-FULL NAME Mary E Middleton

(a) RESIDENCE No. 4096 Federal St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day and year): 1883

7 AGE: Years 47 | Months | Days | IF LESS than 1 day.....hrs. or .....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (City or town): Prince Geo.
(State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Md

14 Informant (Address): Rachel Smyth 4092 Federal

15 Filed ..... 1930 16 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): June 7th 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos.

18 Was disease [illegible] not at place of death? Yes Hospital

Did an operation precede death? Yes Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) ..... M. D.

June 7 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon	June 7 1930
20 UNDERTAKER: Mrs. R. C. Elliott	ADDRESS: 1717 Eastlander

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N 7

Spec.—1-30—M. & T.—250 Blks

E 57851 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57851

CERTIFICATE OF DEATH.

109-80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3624 Roland Ave ST. 13-52 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon J. Fuhrman

(a) RESIDENCE NO. 3624 Roland Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10 1917

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
12	5	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School. pd
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS
10 NAME OF FATHER Irvin L. Fuhrman
11 BIRTHPLACE OF FATHER (city or town) (State or country) md.
12 MAIDEN NAME OF MOTHER Lillian Madaiy
13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Irvin L. Fuhrman
(Address) 3624 Roland Ave

C. HAMPSON JONES, M. D.
Registrar

Filed 7 1930 19 by

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Oct 23 to June 6 19 30.
that I last saw alive on June 6, 19
and that death occurred, on the date stated above, at 5 30 p.m.

The CAUSE OF DEATH* was as follows:
Endocarditis
Pneumonia (Septic)
Sub Septicemia
(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Septic Throat
Blood Stream (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? yes
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Hemolytic Strep
(Signed) Wm J Casey, M. D.
6/6. 193 (Address) 608 Somerset Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL June 9 1930

20 UNDERTAKER Chenowith & Son

ADDRESS 3615 Gunther Ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57852

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-901

E 57852

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary St. 6-9 Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Laura Dalrymple

(a) RESIDENCE NO. The Church Home & Infirmary ST., Broadway WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Jesse L. Dalrymple

6 DATE OF BIRTH (month, day, and year) March 22-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Anne Arundle Co
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Wm H Bird

11 BIRTHPLACE OF FATHER (city or town) Anne Arundle Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Knighton

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundle Co
(State or country) Maryland.

14 Informant Willie E. Dorsey
(Address) Dares Calvert Co. Md.

15 Filed ..... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1930, to June 6, 1930, that I last saw h.er alive on June 6th, 1930, and that death occurred, on the date stated above, at 6.30 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) Senile Arterial Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of "

Was there an autopsy? no

What test confirmed diagnosis? x

(Signed) Vernon H Norwood M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prince Frederick, Md.

DATE OF BURIAL June 8 1930

20 UNDERTAKER Stephens & Greenwood

ADDRESS 1st & Broadway

T-1930

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 57853

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57853

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2017 McHenry ST. 20-28 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Allenbaugh

(a) RESIDENCE NO. 2017 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles T. Allenbaugh

6 DATE OF BIRTH (month, day, and year) Jan. 13 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria Va.

PARENTS

10 NAME OF FATHER Peter Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington. D.C.

12 MAIDEN NAME OF MOTHER Fannie Leach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Charles T. Allenbaugh (Address) 2017 McHenry St.

15 Filed ..., 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 25th, 1930 to June 5th. 1930.

That I last saw her alive on June 5th. 1930

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 3 Yrs.

Chronic Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Ede O'Conolahan M. D.

6/6, 1930 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cathedral Cemetery DATE OF BURIAL June 9 1930

20 UNDERTAKER George L. Schwab ADDRESS 2701 Eutaw Ave.

7-1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 57854 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57854

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1624 W. Lexington ~~xxxx~~ ST., 19-27 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Williams Weems

(a) RESIDENCE NO. 1624 W. Lexington st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. Plus mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Weems

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	Abt. 56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A.A. Co. Md.

PARENTS

10 NAME OF FATHER Reason Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A. Co. Md.

12 MAIDEN NAME OF MOTHER Margret Sellman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A.A. Md.

14 Informant Maggie Connor (Daughter)
(Address) 1408 W. Mulberry st.

15 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1930

17

I HEREBY CERTIFY, That I attended deceased from May 31 st, 1930, to June 4th. 1930, that I last saw her alive on June 4th. 1930, and that death occurred, on the date stated above, at 11;30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brewer Hill, Annapolis, Md. DATE OF BURIAL June 8, 1930

20 UNDERTAKER Mrs. Kate R. Williams ADDRESS 322 N. Schroeder St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

Time of burial extended to
J. Frederick Stampfel
100 ~ 00 | June 11/30

E 57855

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57855

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (NO. W. 25 ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Patrick

(a) RESIDENCE NO. 643 W Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced
HUSBAND of ~~or) WIFE of~~ Unknown

6 DATE OF BIRTH (month, day, and year) April 25 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	1	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.
(State or country)

PARENTS
10 NAME OF FATHER Cornelius
11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.
12 MAIDEN NAME OF MOTHER Martha Williams
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Hospital Record
(Address)

Filed JUN 7 - 1930 C. HAMILTON JONES, Registrar
Reg.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-5-30

17 I HEREBY CERTIFY, That I attended deceased from 5-24, 1930, to 6-5, 1930, that I last saw him alive on 6-5, 1930, and that death occurred, on the date stated above, at 4th P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Lung Abscess
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J Zayko, M. D.
6/5, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden — DATE OF BURIAL 6/9/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57856 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57856

CERTIFICATE OF DEATH.

25-003

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Saubard + Green ST. 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Betty Lee Schillenberg

(a) RESIDENCE NO. 2615 Llewellyn Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 8. 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Raymond T. Schillenberg

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Edna M. Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Raymond T. Schillenberg (Address) 2615 Llewellyn Ave

15 Filed JUN 7 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to June 6, 1930, that I last saw him alive on June 6, 1930, and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia (terminal)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) acidosis, malnutrition

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) W. B. Johnson, M. D.

June 1930 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 6/9/1930

20 UNDERTAKER Wm Cook — ADDRESS 127 St. Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 57857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57857

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST., 7-9 WARD)

2-FULL NAME Bernard J. Duvall

(a) RESIDENCE No. Clarksburg, W. Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21/1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	0	17 16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Weston& W. Va
(State or country)

PARENTS

10 NAME OF FATHER Rolfe Duvall

11 BIRTHPLACE OF FATHER (city or town) Weston& W. Va.
(State or country)

12 MAIDEN NAME OF MOTHER Emma Sheare

13 BIRTHPLACE OF MOTHER (city or town) Weston, W. Va.
(State or country)

14 Informant Mrs. Wm. Young

(Address) 6573 St. Helena Ave.

15 Filed 1930 G. HAWLEY JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abcess of Brain

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Rt Sinus Infection

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of about 1 yr

Was there an autopsy? yes-At Hopkins

What test confirmed diagnosis?

(Signed) Joseph Carter, M. D.
Coroner

6/7/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clarksburg W. Va	June 1930
20 UNDERTAKER	ADDRESS
Geo M. Trice & Son	811 N Wolfe St

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-30—M. & T.—250 Blks.

236804 E 57858

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57858

CERTIFICATE OF DEATH.

X 159-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George D. Prout

(a) RESIDENCE No. Springfield Ohio ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July-8-1929

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
—	10 11	29.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (old)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Harold a Prout

11 BIRTHPLACE OF FATHER (city or town) Ohio (State or country)

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) Ohio (State or country)

14 Informant Howard a. Prout (Address) [illegible]

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-7-1930

17

I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to June 7, 1930, that I last saw him alive on June 7, 1930, and that death occurred, on the date stated above, at 7 10 A. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus. congenital

Life (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 17 May 30

Was there an autopsy? yes —

What test confirmed diagnosis? Operation

(Signed) Ed Compton Brush

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Springfield Ohio — DATE OF BURIAL June 9 1930

20 UNDERTAKER — ADDRESS John D. Whitehill Sons 1900 Eutaw Place

JUN 7 - 1930 HAMPDEN BRANCH

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks. ... Exact statement of OCCUPA-

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57859

CERTIFICATE OF DEATH

90 E 57859

1—PLACE OF DEATH

REGISTERED NO. 19494

CITY OF BALTIMORE: (No. 101 Stratford Road ST. Gilford WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theodore Klein Miller

(a) RESIDENCE NO. 101 Stratford Road ST., Gilford WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Margaret Taylor

6 DATE OF BIRTH (month, day, and year) Nov. 27 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
56 57		6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer) Daniel Miller Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Theodore Klein Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Loudon Co Va

12 MAIDEN NAME OF MOTHER Mary Louise Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fredericksburg Va

14 Informant H. Clay Miller
(Address) Rugby Road apts

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-24, 1930, to 6-7, 1930, that I last saw h[im] alive on 6-6, 1930 and that death occurred, on the date stated above, at 3.00 P m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS

HYPERTENSION

MYOCARDIAL INSUFFICIENCY

(duration) 2+ yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John L. Toomey, M. D.

6/7. 1930 (Address) 1129 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 9th 1930
20 UNDERTAKER	ADDRESS
Henry H. Renkin & Co.	Oakland & Eden Sts

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 57860

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2814 Kats Ave. ST. 15-63 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Kohn

(a) RESIDENCE No. 2814 Kats Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan Kohn

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Heins

(Address) 1439 E. Baltimore St.

JUN 8 - 1930 HARRISON JONES, M. D.

For Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7-1930

17 I HEREBY CERTIFY, That I attended deceased from 3/21, 1930, to 6/7, 1930,

that I last saw her alive on 6/7, 1930,

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Secondary)

(duration) yrs. mos 1 ds.

CONTRIBUTORY Chr. Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Jinkins, M. D.

6/8, 1930 (Address) 2250 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Memorial Park

DATE OF BURIAL June 8 1930

UNDERTAKER Jack Heins

ADDRESS 1439 E. Baltimore St.

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57861

100-001

E 57861

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 22-20 Ward)

2-FULL NAME Raymond M. Colburn

(a) RESIDENCE NO. 645 Washington Blvd. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 31-1897

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	33	2	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Truck-driver
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Thos. Colburn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma C. McAbee

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Paul E. Wagner
(Address) 4219 Louisandale Ave

15 Filed ..... 19.. HARRY JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) autopsy find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D.

6/7, 1930. (Address) 3739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Cemetery Annapolis Md

DATE OF BURIAL June 7 1930

20 UNDERTAKER Jos Joerdens & Son

ADDRESS 2173 E. Pr.

Filed

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—800 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57862

CERTIFICATE OF DEATH

REGISTERED NO. 74001 E 57862

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Bon Secours Hospital ST., 13-52 WARD)

2—FULL NAME Mrs. Lulu Carroll Nash

(a) RESIDENCE NO. Wyman Pk Apt. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 7 mos. 14 ds. How long in U. S., if foreign birth 68 yrs. 7 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roland Nash

6 DATE OF BIRTH (month, day, and year) March 9 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER St John Carroll

11 BIRTHPLACE OF FATHER (city or town) Balto- (State or country) Md.

12 MAIDEN NAME OF MOTHER Lucy McDonald

13 BIRTHPLACE OF MOTHER (city or town) ? ? (State or country) North Carolina

14 Informant Mr Richard Nash (son)
(Address) 3506 Columbia Av

15 Filed ....., 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/7/30

17 I HEREBY CERTIFY, That I attended deceased from 6/3, 1930, to 6/7, 1930, that I last saw h alive on 6/6, 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Jno. E. Stacy Jr., M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's (Govans) Cemy | DATE OF BURIAL June 9 1930.

20 UNDERTAKER Stewart Mortuary Co Balto. | ADDRESS

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—1-12-23—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57863

CERTIFICATE OF DEATH.

88 E 57863

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 Pierce St S. 18-76 WARD)

2-FULL NAME Mary Jane Whalan

(a) RESIDENCE NO. 939 Pierce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of or WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~60~~	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Jessie Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Matilda Rodgers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Clara Diggs

(Address) 939 Pierce

Filed 6 8 1930 . 19 RAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 — 4 — 1930

17

I HEREBY CERTIFY, That I attended deceased from June 2nd, 1930, to June 4th, 1930, that I last saw h alive on June 4th, 1930, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) Months mos ds.

CONTRIBUTORY (Secondary) Indigestion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Jas A Chipm, M. D.

, 19 (Address) 1433 Hagadorn ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 6/8 1930

20 UNDERTAKER Samuel J Hemsley — ADDRESS 1178 W Baltimore

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57864

CERTIFICATE OF DEATH

90 ✓ E 57864

1-PLACE OF DEATH

City of Baltimore: (No. 125 W. Henrietta St. St., 23-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lottie Spriggs.(C)

(a) RESIDENCE NO. 125 W. Henrietta St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 2 mos. 6 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed or divorced (or) WIFE of Joseph Spriggs.(C)

6 DATE OF BIRTH (month, day, and year) March 30, 1895

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	35	2	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Alexander Finckney.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Ellen Hutchins,(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maine.

14 Informant Joseph Spriggs.(C) husband.
(Address) 125 W. Henrietta St.

15 Filed JUN 8 1930 19 C. HARRISON JONES M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion.

Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

6/6, 1930 (Address) 1017 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 1930
20 UNDERTAKER	ADDRESS
Walter B Spriggs	129 Hanlon

Filed

Mar

Reg

Now should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

Booth

E 57865 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 57865

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1026 Whatcoat (ST.) 16-22 (WARD)

2-FULL NAME James S. Booth

(a) RESIDENCE No. 1026 Whatcoat ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10. 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	95	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Booth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant William Booth (Address) 1028 Whatcoat St

15 Filed JUN 8 - 1930 Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/4 1930

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to June 4, 1930, that I last saw h[illegible] alive on June 4, 1930, and that death occurred, on the date stated above, at 5:00 p m

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

Uremia

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj Rhett, M. D.

6/5-, 1930 (Address) 2139 Dek Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Riverstown Md.

DATE OF BURIAL 6/8 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pressman St

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57866

CERTIFICATE OF DEATH

90 E 57866

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1701 Linden Ave. St., 14-20 Ward)

2-FULL NAME Lewis Steigerwald

(a) RESIDENCE NO. 1701 Linden Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Doralyn Steigerwald

6 DATE OF BIRTH (month, day, and year) July 9th. 1850

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	79	10	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

PARENTS

10 NAME OF FATHER Mayer Steigerwald

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bavaria

12 MAIDEN NAME OF MOTHER Sarah ----------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bavaria

14 Informant Mrs. Lewis Steigerwald
(Address) 1701 Linden Ave

15 Filed ..... 19.. C. HAMILTON JONES M. D. Registrar

JUN 8 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7th. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? 1701 Linden

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Douglas Hamilton, M. D.

(Address) 1701 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem.

DATE OF BURIAL 6/9/ 1930

20 UNDERTAKER Hurd Sondheim & Son

ADDRESS 1902 Eutaw Place

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 57867 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57867

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. White

(a) RESIDENCE NO. 2532 W. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Catharine White

6 DATE OF BIRTH (month, day, and year) March 25 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist do

(b) General nature of Industry, business, or establishment in which employed (or employer) City of Balto

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Wm J White

11 BIRTHPLACE OF FATHER (city or town) Penna

(State or country)

12 MAIDEN NAME OF MOTHER Eliz J White

13 BIRTHPLACE OF MOTHER (city or town) Penna

(State or country)

14 Informant Mrs Catharine White

(Address) 2532 W Baltimore

15 Filed JUN 8 1930 HAMILTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 6, 1930, that I last saw him alive on June 6, 1930, and that death occurred, on the date stated above, at 2 45 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation

(Signed) Samuel J. Kopus, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL 6-9 1930

20 UNDERTAKER Jos R Kirby Sallad ADDRESS Fayette

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—2-29-28—L. F. S.—500 Bks.

E 57868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 57868

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5944 Kavon Ave ST. 26-42 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael C Chapman

(a) RESIDENCE NO. 5944 Kavon Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER James Chapman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Chapman

(Address) 5944 Kavon Ave

15 Filed JUN 8 1930 C. HAMPSTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1930, to June 6, 1930, that I last saw h[illegible] alive on June 5, 1930 and that death occurred, on the date stated above, at 7 30 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Prostate with Bladder Involvement

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of about March

Was there an autopsy? no

What test confirmed diagnosis? Symptoms.

(Signed) Chas Smith, M. D.

June 7, 1930 (Address) 4706 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cath Church	June 9 1930
20 UNDERTAKER	ADDRESS
Ford Catholic	1724 Gay.

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57869

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57869

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 N. Milton Ave ST. 6-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bauer

(a) RESIDENCE NO. 124 N. Milton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Bauer

6 DATE OF BIRTH (month, day, and year) Feb. 16/1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER — Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Lehias Koster

(Address) 124 N. Milton Ave.

15 Filed 8 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6/30

17

I HEREBY CERTIFY, That I attended deceased from Jan 1930 to June 6 1930, that I last saw him alive on June 6 1930, and that death occurred, on the date stated above, at 3 o'clock P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(arteriosclerosis)

uncertain (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilation of Heart

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Faulkner, M. D.

, 19 (Address) 119 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL June 8 1930

20 UNDERTAKER Philip Stewig

ADDRESS 2016 Orleans St.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-30—M. & T.—250 Blks.

E-57870

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57870

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2001 Homewood Ave (St.) 9-16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy R. Dallam

(a) RESIDENCE NO. 2001 Homewood Ave (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Nov. 25/1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Benjamin F. Dallam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary McNeir

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Wm L. Dallam (Address) 2001 Homewood Ave

15 Filed JUN 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 1928, 19, to June 6, 1930, that I last saw her alive on June 5, 1930, and that death occurred, on the date stated above, at 1 30 PM m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Uremic Convulsions, Hypertension

(R. Hemiplegia "4 days duration")

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension & Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Chemical Tests

(Signed) R. C. Carman, M. D.

6-7-, 1930 (Address) 1701 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem.

DATE OF BURIAL June 9 1930

UNDERTAKER Philip Herwig

ADDRESS 2016 Eutaw

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-30—M. & T.—250 Blks

E 57871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 57871

146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST. 21-31 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Sears

(a) RESIDENCE No. 427 W Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of W. Alvin Sears

6 DATE OF BIRTH (month, day, and year) February 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic (waitress)

(b) General nature of industry, business, or establishment in which employed (or employer) 020

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Wilson Beard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ala

12 MAIDEN NAME OF MOTHER Mary Sears

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ala.

14 Informant L. Sears

(Address) 427 W Baltimore

Filed JUN 8 - 1930 HAMILTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-5-30

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1930, to June 5, 1930, that I last saw h[illegible] alive on June 5, 1930, and that death occurred, on the date stated above, at 2 08 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) short mos 12 ds.

CONTRIBUTORY (Secondary) Congenital Syphilis

(duration) short yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M McClure M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL June 9 1930

20 UNDERTAKER John H Tradum — ADDRESS 102 Pond Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks. Annie M. Wilson

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57872

CERTIFICATE OF DEATH.

90 E 57872

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 Division St., 14-59 WARD)

2-FULL NAME Annie M. Wilson

(a) RESIDENCE NO. 2223 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter Wilson

6 DATE OF BIRTH (month, day, and year): Unk 1858

7 AGE: Years 72; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jas. Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Burr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Winnie Wilson (Address) 2223 Division St

15 Filed JUN 3 1930 C. HARRISON JONES, Registrar

Reg RPK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 11th, 1930, to June 6, 1930, that I last saw her alive on June 6th, 1930, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocardial Insufficiency

(duration) 2 yrs. 1/2 mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) Geo. H. Langenbach M. D.

6-7, 1930 (Address) 2213 N. Monastery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: June 10 1930

20 UNDERTAKER: John H Frazier — ADDRESS: 1021 Pennsylvania

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

Frushour.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57873

CERTIFICATE OF DEATH.

40

E 57873

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3434 Parkheight Ave ST 15-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stella E. Frushour

(a) RESIDENCE NO. 3434 Parkheight ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry V. Frushour

6 DATE OF BIRTH (month, day, and year) April 8, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John L. Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Harry V. Frushour (Address) 3434 Parkheight Ave

15 Filed 1930 H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1930, to June 7, 1930, that I last saw her alive on June 7, 1930, and that death occurred, on the date stated above, at 7 30/8 m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Septicemia Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Columbus M. D.

, 19 (Address) 719 Medical Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL June 9 1930

20 UNDERTAKER Harry H. Witzke — ADDRESS 4101 Edmondson

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

E 57874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 74-002 E 57874

1-PLACE OF DEATH St. Agnes Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 25-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Hepting

(a) RESIDENCE No. 1301 Riviera Ave. ST. Catonsville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~OR WIFE of~~ Sophia Hepting

6 DATE OF BIRTH (month, day and year) Unknown 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carp. Del Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Construction

(c) Name of employer

9 BIRTHPLACE (city or town) Balto County Md (State or country)

PARENTS

10 NAME OF FATHER Augustus Hepting

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hosp Record (Address)

15 Filed 8-1830 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) June 8 1930

17

I HEREBY CERTIFY, That I attended deceased from 6-6 .1930 to 6-8 .1930.

that I last saw h[illegible] malive on 6-8 .1930,

and that death occurred, on the date stated above, at 11:05 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) Ernest Spencer Jr. M. D.

. 19 (Address) St agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt Johns Cem DATE OF BURIAL June 10 1930

20 UNDERTAKER Easton Sons & Edlich ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 57875

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57875

CERTIFICATE OF DEATH

44 E 57875

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 S. Dallas ST., 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Ulrich

(a) RESIDENCE NO. 419 S. Dallas ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER John Ulrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Walter J. Ulrich
(Address) 419 S. Dallas St.

15 JUN 8 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1930

17 I HEREBY CERTIFY, That I attended deceased from May, 1930, to June 4, 1930, that I last saw him alive on June 4, 1930 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. M. & S.

(Signed) John J. Rogers, M. D.

, 19 (Address) 1327 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park June 7	1930
20 UNDERTAKER	ADDRESS
John M. Weber	1124 Eastern Ave

important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88 E 57876

E 57876

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 E. Lombard ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael M. Betka

(a) RESIDENCE NO. 1825 E. Lombard ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Betka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anges Pileohowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anges Betka

(Address) 1825 E Lombard St.

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1930

17 I HEREBY CERTIFY, That I attended deceased from April 4th, 1930, to June 6th, 1930, that I last saw h in alive on June 6th, 1930 and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis (Streptococcus Viridans)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Odema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Bacteriological findings.

(Signed) Michael A. Abrams, M. D.

6/7/30 19 (Address) 2360 Eutaw place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. DATE OF BURIAL June 13 1930

20 UNDERTAKER John W Weber Sr ADDRESS

important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57877

99-001 ✓ E 57877

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2023 Portugal ST. 2-4 WARD)

2—FULL NAME William Kuchciński

(a) RESIDENCE NO. 2023 Portugal ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Wife

(Address) 202 E. Fitzgerald St

15 Filed JUN 8 1930 G. HAROLD JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1930

17 I HEREBY CERTIFY, That I attended deceased from May 31st, 1930, to June 5th, 1930,

that I last saw h. alive on , 19

and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Senn

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L. Wiener, M. D.

6-8, 1930 (Address) 308 E. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus June 10	1930
20 UNDERTAKER	ADDRESS
John M Weber	Mt Auburn

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57878 — CERTIFICATE OF DEATH — 74-001 V — E 57878

1—PLACE OF DEATH Little Sisters of the Poor. REGISTERED NO.

CITY OF BALTIMORE: (No. 1200 Valley St. ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Callahan

(a) RESIDENCE NO. 1200 Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Callahan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Roark

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor
(Address) 1200 Valley St Baltimore Md

15 Filed ... 1930 C. HAMPSON JONES, M. D.
By ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6/30

17 I HEREBY CERTIFY, That I attended deceased from 5/20, 1930, to 6/6, 1930, that I last saw h[er] alive on 6/3—, 1930, and that death occurred, on the date stated above, at June 6th 6.45 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Bernard Wirth, M. D.

6/8, 1930 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	June 9 1930
20 UNDERTAKER	ADDRESS
Rita Wiedefeld	914 Fremont Ave

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57879

46 E 57879

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. ST. 2-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Jerome.

(a) RESIDENCE NO. 1739 E. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	White	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3rd 1927

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Lee Jerome

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Laura Venick

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Lee Jerome

(Address) 1739 E. Pratt st

15 Filed JUN 8 1930 C. HARRY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1930.

17 I HEREBY CERTIFY, That I attended deceased from 2/27/30, 19 30, to 6/6, 19 30; that I last saw her alive on 6/6, 19 30; and that death occurred, on the date stated above, at 3:00 a. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Uterus

(duration) One yrs. mos ds.

CONTRIBUTORY (Secondary) Inanition

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Partial

What test confirmed diagnosis? History & Microscopic Post Mortem

(Signed) Burgheltz, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Lawns Lawn

DATE OF BURIAL June 9 1930

UNDERTAKER Stephen J. Fialkowski

ADDRESS 1000 S. Kenwood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E57880 HEALTH DEPARTMENT—CITY OF BALTIMORE E57880

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 24001

CITY OF BALTIMORE: (No. 217 S. Exeter ST., 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick Wollenweber

(a) RESIDENCE NO. 217 S. Exeter ST., WARD 3rd
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora O'Dea

6 DATE OF BIRTH (month, day, and year) Dec. 16, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveler

(b) General nature of industry, business, or establishment in which employed (or employer) Gibbs Preserving Co.

(c) Name of employer Wm. Gibbs

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Wollenweber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mathilde Lehmann

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Miss Mathilde Wollenweber
(Address) 217 S. Exeter St.

15 Filed G. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from July, 1928, to June 6, 1930, that I last saw h in alive on June 6, 1930 and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
Cerebral arterio sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. J. Feuglon, M. D.

6/8, 1930 (Address) 700 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. — DATE OF BURIAL June [illegible] 30.

UNDERTAKER Wendell J. Heppel — ADDRESS 30[illegible]

JUN 9 - 1930

IMPORTANT: PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

237671
E 57831

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57831

CERTIFICATE OF DEATH. X 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME May Phigpen

(a) RESIDENCE No. Washington D.C. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	married.

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 3 - 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Officer 070

(b) General nature of industry, business, or establishment in which employed (or employer) Janitress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) District of Columbia

PARENTS

10 NAME OF FATHER Wm altman

11 BIRTHPLACE OF FATHER (city or town) (State or country) S Car

12 MAIDEN NAME OF MOTHER Harriet E Chovin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S Car

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 8 1930 19 C. M[illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June - 7 - 1930

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1930, to June 7, 1930, that I last saw her alive on June 7, 1930, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Atrophy - liver

[illegible]

[illegible]

Unknown (duration) yrs. mos da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) James Bordley M.D., M. D.

6-8, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C.

DATE OF BURIAL June 10 19 30

UNDERTAKER Ebenezer Lee

ADDRESS 1305 Florida Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 57882

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57882

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 158 Colvin ST. 5-8 WARD)

2-FULL NAME Lula J Spencer

(a) RESIDENCE No. 158 Colvin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) — 070

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Daniel Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elsie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William J Spencer (Address) 158 Colvin St.

15 Filed JUN 8 - 1930 C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1930

17

I HEREBY CERTIFY, That I attended deceased from about 1 yr ago 19..... to June 6 1930

that I last saw h[illegible] alive on June 6 1930

and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(duration) 1 about or more yrs. mos ds.

CONTRIBUTORY (Secondary) Anthemia

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) [illegible] M. D.

, 19 (Address) 1904 E. Lafayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Albury cemetery — DATE OF BURIAL June 10, 30

20 UNDERTAKER Edward Bryan — ADDRESS 1691 Orleans St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57883

CERTIFICATE OF DEATH

117 E 57883

1—PLACE OF DEATH Provident Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. 3-4 ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jasper Brown

(a) RESIDENCE NO. 310 S Caroline St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Cl	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Walter Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Lillie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant Michel Johnson

(Address) 1916 St Mathews St

15 Filed 8-1930, 19 HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6/30

17 I HEREBY CERTIFY, That I attended deceased from 3/14, 1930, to 6/6, 1930, that I last saw h[illegible] alive on 6/6, 1930 and that death occurred, on the date stated above, at 11 52 a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

Fecal Fistula

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Ruptured Appendix

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? yes Date of 3/15/30 6/4/30

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Bernard Sam, M. D.

6/6, 1930 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dillery N. C — DATE OF BURIAL June 9. 1930

20 UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans st

IMPORTANT.—Please write plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E. 57884

Charles W Blandford

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 57884

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 920 N Monroe St. Parkway 27 - 57 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. Wells Blandford

(a) RESIDENCE NO. 920 N Monroe St. Parkway Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cordelia G Blandford

6 DATE OF BIRTH (month, day, and year): Sept 21, 1876

7 AGE: Years 53 | Months 8 | Days 15 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Sheet Metal Worker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Earle & Young

9 BIRTHPLACE (city or town)
(State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jno H Blandford

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Anne Co Md

12 MAIDEN NAME OF MOTHER: Debra Wells

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Chester Co Pa

14 Informant: Cordelia G Blandford
928 N Monroe St Parkway

File No. [redacted] C. HARRY JONES, Registrar

Jan 3 - 1930 For

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bruce Morrison, M. D.

June 9, 1930 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: June 9 1930

20 UNDERTAKER: Mr Mrs. John H. Tempel - Lon

ADDRESS: 801 N. Fayette

Use should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 57885

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57885

CERTIFICATE OF DEATH.

118

1-PLACE OF DEATH Mercy Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 27-4 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Miller

(a) RESIDENCE NO. 3100 Gibbon Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel A. Miller

6 DATE OF BIRTH (month, day, and year) 1/1/1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Orr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records (Address)

15 Filed JUN 9 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-6-30

17 I HEREBY CERTIFY, That I attended deceased from 6-4, 1930 to 6-6, 1930, that I last saw h[illegible] alive on 6-6, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Post Operative Hemorrhage

(Duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Enterostomy 6-5-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Operative

(Signed) J. Leyko, M. D.

6/6, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 6/9/30, 19

UNDERTAKER Mary T. Petty

ADDRESS 1735 Harford

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

1-30—M. & T.—100 B—50L

E 57886

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 1

E 57886

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Enroute Hopkins Hospital ST., 7-9 WARD)

2-FULL NAME Samuel Chinn

(a) RESIDENCE NO 513 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 53				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Fannie Green

(Address) 1604 McElderry St

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 7/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull (Vault)
Accidentally fell when scaffold rope broke while painting (Fairmount ave nr W. sington)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D. Coroner

6/9/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Auburn. C

DATE OF BURIAL 6/9/30 19

20 UNDERTAKER Mrs Ida Snowden

ADDRESS 1708 Madison

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-30—M. & T.—250 Blks.

237637

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57887

CERTIFICATE OF DEATH.

E 57887

1-PLACE OF DEATH: JOHNS HOPKINS Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2 ST., 6-9 WARD)

2-FULL NAME: Bertha Evans

(a) RESIDENCE NO. 423 N. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	black	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer): unknown

(c) Name of employer: unknown

9 BIRTHPLACE (city or town) (State or country): N. Carolina

PARENTS

10 NAME OF FATHER: John Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Carolina

12 MAIDEN NAME OF MOTHER: Anna Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Carolina

14 Informant: Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 9 1930 C. HUNTER JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-6-30

17 I HEREBY CERTIFY, That I attended deceased from 6-3-, 19 30, to 6-6-, 19 30,

that I last saw her alive on 6-6-, 19 30,

and that death occurred, on the date stated above, at 3 45 P m.

The CAUSE OF DEATH* was as follows:

Generalized peritonitis

(Colon bacillus).

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Primary pelvic infection

(duration) yrs. 6 mos. da. ovarian

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 6-4-30

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Edmund P. Harrison, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pittsgah N. C.

DATE OF BURIAL: Jun 9 1930

UNDERTAKER: Porter & Williams

ADDRESS: 1515 McElderry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57888 — **CERTIFICATE OF DEATH** — **E 57888**

90

REGISTERED NO. 16-42

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1901 W. Lanvale ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella W. Geoghegan

(a) RESIDENCE NO. 1901 W. Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 3 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert T. Geoghegan

6 DATE OF BIRTH (month, day, and year): Feb. 22, 1862

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: George H. Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Georgina Meeks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Robert T. Geoghegan
(Address): 1901 W. Lanvale St.

15 Filed JUN 9 - 1930, RAYMOND JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to June 7, 1930, that I last saw h.er alive on June 7, 1930 and that death occurred, on the date stated above, at 7:20 p. m.

The CAUSE OF DEATH* was as follows:

Hypertension
Chronic Valvular Heart disease
Cerebral Hemorrhage
Chronic Heart Disease (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Coulter Jones, M. D.

. 19 (Address) 816 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: June 10 1930

20 UNDERTAKER: Robert L. Little

ADDRESS: 3700 Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57889

CERTIFICATE OF DEATH

7-4001

E 57889

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 603 W. Redwood St., 4-30 Ward)

2-FULL NAME John Maggio

(a) RESIDENCE NO. 603 W. Redwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincenza Maggio

6 DATE OF BIRTH (month, day, and year) Nov 6 - 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	58	6	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Maggio

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Mrs. V. Maggio
(Address) 40 S. High St

15 Filed 1930 C. HARRISON JONES, M. D., Registrar
by

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zollers, M. D.

6-7, 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL 6-9 1930

20 UNDERTAKER Wendell J. Kippel ADDRESS 300 N. Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 57890

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57890

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Sharp. 23-31 WARD)

2-FULL NAME Beulah Wilson

(a) RESIDENCE NO. 1125 Sharp ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Wilson

6 DATE OF BIRTH (month, day, and year) ?-?-1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Female Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) worked on dump.

(c) Name of employer Mr. Foreman Rockhill S. C.

9 BIRTHPLACE (city or town) (State or country) .....

PARENTS

10 NAME OF FATHER Charles Wilkes

11 BIRTHPLACE OF FATHER (city or town) Rockhill S.C. (State or country)

12 MAIDEN NAME OF MOTHER Janie Grant.

13 BIRTHPLACE OF MOTHER (city or town) Rockhill (State or country) S. C.

14 Informant Joseph Wilkes (Address) 1016 W. Cross St.

Filed JUN 9 1930 J. C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-6-30

17 I HEREBY CERTIFY, That I attended deceased from 5-24-, 1930, to 6-2-, 1930, that I last saw her alive on 6-2-, 1930, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary hemorrhage

10 minutes (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Pulmonary phthisis (duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? City dump.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory + physical examination

(Signed) Jas. P. Saunders, M. D.

6-7-1930 (Address) 1029 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct.

DATE OF BURIAL June 9 1930

UNDERTAKER J. E. Brown & Son

ADDRESS 1011 W. Mond

Spec.—2-29-28—L. F. S.—500 Blks.

E 57891

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57891

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1311 Cambria ST. 25-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James. G. Sites

(a) RESIDENCE NO. 1311 Cambria ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or ~~Divorced, (write the word)~~
Male	white	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Sites

6 DATE OF BIRTH (month, day, and year) June 12 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	10	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Andrew J. Sites

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Workman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Workman

14 Informant Mrs. Mary E. Sites

(Address) 1311 Cambria St

Filed JUN 9 1930 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1930

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to June 7, 1930

That I last saw h[illegible] alive on June 7, 1930

That death occurred, on the date stated above, at 6 45 A m.

The CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis

Chronic Myocarditis

Long Standing

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lee D. Hoffa M. D.

1930 (Address) 4700 Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westernbeach	June 10 1930
20 UNDERTAKER	ADDRESS
Josephsons Bond	2078 E. Pra

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 57892

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 199 ✓ E 57892

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Hosp (St.) 4-30 (WARD)

2-FULL NAME Virgie Gibson

(a) RESIDENCE No. Laurel Md ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby-1-1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	4	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Mrs Gibson

9 BIRTHPLACE (city or town) (State or country) Laurel Md

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Virgie Gibson

(Address) Laurel Maryland

15 Filed 6-9 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Auto in which she was a ride collided with another auto as it entered Blv'd

(duration) hrs. mos. ds.

CONTRIBUTORY Traumatic Shock

Traumatic Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? West Blv'd & Union Bottom Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Surgical

(Signed) J. J. France, Coroner, M. D.

1930 (Address) 2139 N Eden

(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bacon's Cemetery — DATE OF BURIAL June 10 1930

UNDERTAKER E. N. Fisher — ADDRESS Laurel Md.

CAUSE OF DEATH. In plain terms, so that it may be properly classified. Exact statement is important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57893

CERTIFICATE OF DEATH.

49 E 57893

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 4776 Stanwood Ave 26-41 Ward)

2-FULL NAME Barbara E. Linsenmeyer

(a) RESIDENCE NO. 4776 Stanwood Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced: (or) WIFE of Leo Linsenmeyer

6 DATE OF BIRTH (month, day, and year): — — 1871

7 AGE: Years 58 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Balto.

PARENTS

10 NAME OF FATHER Ed. Schwarz

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Pick

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant Gertrude Conner

(Address) 4776 Stanwood Ave

15 Filed JUN 9 - 1930 19 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to June 7th, 1930, that I last saw h.r alive on June 5th, 1930, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Radical Hemiplegia ?

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? at Home & death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical diagnosis

(Signed) W. W. Keown, M. D.

6/8, 1930 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

Date of Burial 6/10 1930

20 UNDERTAKER Leo F. Kahlert

ADDRESS 318 Eutaw St

IMPORTANT. Every question on this certificate should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 57894 HEALTH DEPARTMENT—CITY OF BALTIMORE

- CERTIFICATE OF DEATH

E 57894

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No.) 1000 Eaton Ave ST. 21-29 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Wayson

(a) RESIDENCE NO. 1009 Stricker St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Wayson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Buffalo (State or country) New York

PARENTS

10 NAME OF FATHER Charles Metz

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Ellen Foy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Jenkins Memorial Hosp 1000 Eaton Ave

JUN 9 - 1930 Filed C. HOWARD JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1930

17

I HEREBY CERTIFY, That I attended deceased from July 12, 1929, to June 9, 1930, that I last saw her alive on June 9, 1930, and that death occurred, on the date stated above, at 6-15 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Evidence

(Signed) Ernest Spencer jr. M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Annapolis Md

DATE OF BURIAL Jun 12 1930

20 UNDERTAKER E L Hopkins

ADDRESS Annapolis Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 57895 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57895

Dr Larson 3500 Garrison Ave

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3525 Belvidere Ave St. 27-56 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George D Smith

(a) RESIDENCE. No. 3525 Belvidere Ave St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Smith

6 DATE OF BIRTH (month, day, and year) Jan 27-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George H Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Mary Stansbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Annie Martin (Address) 3525 Belvidere Ave

15 Filed ... 19... C. MARION JONES, M. D. Registrar

JUN 9 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/7 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to June 7, 1930, that I last saw h alive on June 7, 1930, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Queen, M. D.

6/7. 1930 (Address) 3501 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys (Govans)	June 10 1930
20 UNDERTAKER	ADDRESS
Franklin W Leitz	709 W 33rd St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS' should be stated

1-30—M. & T.—100 B—50L

E 57896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 57896

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5704 Fair Oaks Ave ST. 27-43 WARD)

2-FULL NAME Joseph H. Schindler

(a) RESIDENCE NO 5704 Fair Oaks Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Schindler

6 DATE OF BIRTH (month, day, and year) Jun 10/1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	11	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Patternm Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER John Schindler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jennie Schindler
(Address) 5704 Fair Oaks Ave

15 Filed 6/10, 192 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] Coroner, M. D.

6/9/30 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trenton N.J.

DATE OF BURIAL 6/10 1930

20 UNDERTAKER Wilham Cook

ADDRESS 1247 St Paul St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57897 E 57897

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto. Genl Hosp ST. 26-1 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rosa Braunschweiger

(a) RESIDENCE NO. 3232 O'Donnell ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. NOTE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Braunschweiger

6 DATE OF BIRTH (month, day, and year): Aug. 22 - 1868

7 AGE — Years: 61 — Months: 9 — Days: 13 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Jacob Scheffllein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Weiler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm. Braunschweiger
(Address): 3232 O'Donnell St

15 Filed ....., 19.... C. JAMESON JONES, REGISTRAR

9-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/9 1930

17

I HEREBY CERTIFY, That I attended deceased from ~~5~~ 5/30/1930, to 6/7, 1930,

that I last saw h... alive on 6/9 [redacted], 1930,

and that death occurred, on the date stated above, at 9-5 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic C-V-R disease
(Chronic myocarditis)
(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary): Acute Cardiac dilatation
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical + laboratory

(Signed) S. A. Alessi, M. D.

, 19 (Address) West Balto. Genl Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: June 12 1930

UNDERTAKER: George W. Zirkler

ADDRESS: 1787 E. Eager at

Spec.—1-30—M. & T.—250 Blks.

E 57896 57898 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57896 57898

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5719 (Street) Pimlico Road (Ward) 27-54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth D. Fisher

(a) RESIDENCE No. 5719 Pimlico Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Samuel F. Fisher

6 DATE OF BIRTH (month, day, and year) Feb. 22. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 0'7

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Kemper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna D. ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Samuel F. Fisher

(Address) 5719 Pimlico Road

15 Filed JUN 9 1930, 19 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7. 1930.

17

I HEREBY CERTIFY, That I attended deceased from May 23, 1930, to June 7, 1930, that I last saw h[illegible] alive on June 7, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Thyreoadenal Insufficiency.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) [illegible] M.D.

, 19 (Address) 5917 Park Heights

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	June 10 1930
UNDERTAKER Horace A. Burgee	ADDRESS 3331 Falls Road

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

57899

E 57899.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1001 57899

100 E 57899

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. S. 26-27 WARD)

2-FULL NAME Emma Fowler

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address)

15 Filed ..., 1930 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-4-30

17 I HEREBY CERTIFY, That I attended deceased from 8-15, 1918, to 6-4, 1930, that I last saw her alive on 6-4, 1930, and that death occurred, on the date stated above, at 8:00 P m.

The CAUSE OF DEATH* was as follows:

Chronic Ulceration of right lower leg.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Dumpkins, M. D.

6-5, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

UNDERTAKER

ADDRESS JUN 9 - 1930

Commissioner Health

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

57900 ✓ 57900

E 57900 E 57900

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Watson

(a) RESIDENCE NO. 110 S Mc Culloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Louis Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mandy ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Record.

(Address)

15 Filed ....., 19 .... C. HAMPSON JONES, M.D. For ... Registrar

6-9-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-6-30

17 I HEREBY CERTIFY, That I attended deceased from 4-26, 1930, to 6-6, 1930, that I last saw him alive on 6-6, 1930, and that death occurred, on the date stated above, at 12 35 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis

(duration) Unknown mos da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 5-23-30

Was there an autopsy? O-N

What test confirmed diagnosis? Operation

(Signed) L. H. Levenstein, M. D.

6-7, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Health Commissioner Health.

ADDRESS JUN 9 - 1930

✓ TION is very important. See instructions on back of certificates.

...ATION OF DEATH, in plain terms, so that it may be properly classified. Exact statement of OCC...

Spec.—1-30—M. & T.—250 Blks.

57901 E 57901

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 76-37 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Griffin

(a) RESIDENCE NO. ? ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Jennie

6 DATE OF BIRTH (month, day, and year) June 9, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49	50	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of (Address) Balto. City Hospitals

15 Filed JUN 9 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-7-30

17 I HEREBY CERTIFY, That I attended deceased from 5-20-30, 19..., to 6-7-30, 19...,

that I last saw him alive on 7:15 A. M., 19...,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Md. Home. E. Hospital

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

6-9, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Back of Hill DATE OF BURIAL

20 UNDERTAKER Peter Bryan 1634 Eutaw Pl. ADDRESS

Commissioner of Health. JUN 9 - 1930

UNIVERSITY OF MARYLAND

TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 57902 57902

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ 57902 E 57902

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hopkins Hospital ST. 7-9 WARD

2-FULL NAME Thomas D. Harris

(a) RESIDENCE NO ... Stevenson, Md. ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie V. Harris

6 DATE OF BIRTH (month, day, and year) Apr 17/1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	05	1	22 21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer do
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer J. LLoid Clark

9 BIRTHPLACE (city or town) (State or country) Olney, Md.

PARENTS

10 NAME OF FATHER John Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lloyd Kaiser (Address) Laurel Md.

15 Filed ... 19... C. HAMPSON JONES, M. D., Registrar

9 - 1930 acs

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ni death on the day stated above.

The CAUSE OF DEATH* was as follows:

Transverse Myelitis-Fractured Cervical vertebra. Accidently thrown against hay rack while assisting to milk a cow. (duration) ... yrs. ... mos 9 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) J. K. Boies, M. D. Coroner

6/9/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Spencerville Md	June 11 1930
20 UNDERTAKER Lloyd Kaiser	ADDRESS Laurel Md

FROM BE very important. See instructions on back of certificate. CAUSE, DURATION OF OCCUPA-

Spec.—1-30—M. & T.—250 Blks

729 Dr Hoag Washington Blvd

E 57903 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57903

57903 CERTIFICATE OF DEATH. 90 57903

1-PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 2703 Hampden ST. 24-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily J. McCauley

(a) RESIDENCE NO. 773 Washington ST. Blvd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E. Winfield McCauley

6 DATE OF BIRTH (month, day, and year) July 15, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Eldore Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Hanna Leahy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant E. Winfield McCauley (Address) 773 Washington Blvd

15 Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to June 9, 1930, that I last saw h-- alive on June 8, 1930, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 1 mos de.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 de.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Worley Hoag, M. D.

June 9 1930 (Address) 729 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden — DATE OF BURIAL June 11 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul

IMPORTANT. See instructions on back of certificates.

Spec. 1-30—M. & T.—250 Bks.

57904 ✓ 57904

E 57904 E 57904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 16-27 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. E. Nagle

(a) RESIDENCE NO. 630 N. Gilmor St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Jan. 30, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Catonsville

(State or country) Md.

PARENTS

10 NAME OF FATHER George O. Nagle

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Evelyn Brooks

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 1930 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-7-30

17 I HEREBY CERTIFY, That I attended deceased from 1-8-30, 19..., to 6-7-30, 19...,

that I last saw him alive on 6-7-30, 19...,

and that death occurred, on the date stated above, at 5:40 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic + acute.

(duration) More than yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) More than yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

6-7, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 6/10 1930

20 UNDERTAKER Wm. Cook

ADDRESS 1217 St. Paul St

TION IS very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

57905

E 57905 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57905

Dr. John Bubert Park Hghts + Woodland Ave

57905

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3104 Virginia Ave ST. 27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Karl W. Vohyer

(a) RESIDENCE NO. 3104 Virginia Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Helena Vohyer

6 DATE OF BIRTH (month, day, and year) May 14th 1865

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65		25 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Walter Vohyer

(Address) 3104 Virginia Ave

15 Filed JUN 9 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1930 to June 8, 1930

that I last saw him alive on June 8, 1930

and that death occurred, on the date stated above, at 8.30 P. m. (Standard Time)

The CAUSE OF DEATH* was as follows:

Multiple Liposmatosis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Bubert M. D.

, 19 (Address) 4754 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 6/11/1930

20 UNDERTAKER Wm Cook 1217 — ADDRESS St Paul St

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E.57906 ✓ E.57906

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) H. Agnes Asylum ST. (WARD) 25-12

2-FULL NAME Claud Maymond Gunnells

(a) RESIDENCE NO. 606 Inglewood Ave. Catonsville WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day and year): March 11, 1928

7 AGE: Years 2 Months 2 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Edward R. Gunnells

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ella R. Howe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Edward R. Gunnells Catonsville Md.

15 C. HAMPSON JONES M. D. Registrar

9 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): June 9. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1930 to June 9, 1930.

that I last saw him alive on June 9, 1930.

and that death occurred on the date stated above, at 10.40 A.M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis + Peritonitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Laparotomy

(Signed) Marshall B. Post M. D.

June 9. 1930 (Address) Catonsville Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harmony Cem. Jer. DATE OF BURIAL: June 11 1930

20 UNDERTAKER: Easton Sons & Ellicott ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.— Bks.

57907
E 5790

HEALTH DEPARTMENT—CITY OF BALTIMORE

57907
E 5790

CERTIFICATE OF DEATH

1-PLACE OF DEATH Shell Eastern Petroleum Products Corp.

City of Baltimore: (No. Curtis Bay. St., 25-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Giovanni Robbiano.

(a) RESIDENCE NO. Genoa, Italy. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, widowed or divorced
HUSBAND of
~~WIFE of~~ Anita Robbiano.

6 DATE OF BIRTH (month, day, and year) June 8, 1894

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	36	0	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chief Mate
(b) General nature of industry, business, or establishment in which employed (or employer) S/S Carpena.
(c) Name of employer

9 BIRTHPLACE (city or town) Silvano D'Orba, Italy
(State or country)

PARENTS

10 NAME OF FATHER Lorenzo Robbiano.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy.

12 MAIDEN NAME OF MOTHER Ermenia Melli.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy.

14 Informant Capt. Piero Pronzato.
(Address) S/S Carpena. Genoa Italy.

15 F[illegible] 1[illegible]-1930 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia, due to inhalation of fumes from Gasoline in tank of s/s Carpena. Occidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Eisenhardt, M. D.

6/9, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL June 10, 1930

20 UNDERTAKER Frank V. Pikitone

ADDRESS 2818 E. Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

57908

E 57908

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57908

E 57908

31

1—PLACE OF DEATH

BROOKLYN

CITY OF BALTIMORE: (No. 532 Annabel. Ave. ST. 25-75 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME W. wilson White.

(a) RESIDENCE NO. 532 Annabel Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 7 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of -------

6 DATE OF BIRTH (month, day, and year) Oct. 19. 1912

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
17	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Errand Boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Barney A. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Emma A. Travers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore. Md.

14 Informant Mrs. Emma A. White.

(Address) 532 Annabel. Ave.

15 Filed 9 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1 1930 to June 7 1930

that I last saw him alive on June 6 1930

and that death occurred, on the date stated above, at 4.30. A.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hagerman M. D.

6/9, 1930 (Address) 1 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL June 10 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 E. 5th St

Spec.—1-30—M. & T.—250 Blks.

E 57909 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 57909

CERTIFICATE OF DEATH

38

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto City Hosp

CITY OF BALTIMORE: (No. Balto Md ST. 14-20 (WARD)

2-FULL NAME William Welch

(a) RESIDENCE NO. 610 Pitcher St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Welch

6 DATE OF BIRTH (month, day, and year) Feb. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records at Balto City Hosp (Address)

Filed 9-1930, 19 H. M. SIMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-6-30

17 I HEREBY CERTIFY, That I attended deceased from 4-26-, 1926, to 6-6-, 1930,

that I last saw him alive on 6-2-, 1930,

and that death occurred, on the date stated above, at 12.10 A. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lueic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal Fluid Clinical findings

(Signed) Henry H. Donnell, M. D.

6/6, 1930 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 6/10/1930

20 UNDERTAKER Mrs. Geo. H. Holland — ADDRESS 1631 Druid Hill Ave

Very important—See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E. 57910 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 57910

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St. 17-23 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Callie Stevens

(a) RESIDENCE NO. 1209 Myrtle Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	Single

3a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ? 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs. Georgie James

(Address) 1520 Park Ave

15 Filed 1930, 19 M.M.H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8-30

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1930, to June 8, 1930, that I last saw h[illegible] alive on June 8, 1930 and that death occurred, on the date stated above, at 8 45 a.m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio-vascular-renal Disease

(duration) about 4 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Carroll M. St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Eastville, Va.

DATE OF BURIAL 6/10/30

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 163 Druid Hill Ave

IMPORTANT. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57911

CERTIFICATE OF DEATH

196

E 57911

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Roosevelt Park 13-52 Ward)

2-FULL NAME Calvin L. Cross.

(a) RESIDENCE NO. 3747 Elm Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31 1912

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	17	10	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) md.
(State or country)

PARENTS

10 NAME OF FATHER Bryan Cross

11 BIRTHPLACE OF FATHER (city or town) md.
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Pickette

13 BIRTHPLACE OF MOTHER (city or town) md.
(State or country)

14 Informant Bryan Cross
(Address) 3747 Elm Ave

15 Filed JUN 9 1930 HAMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electrocuted - Coming in Contact with a Live Wire of Electric Light Pole.

Accidental (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	June 10 1930
20 UNDERTAKER	ADDRESS
Greenwell & Son	3615 Reisterstown Rd

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 57912 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57912

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3642 Ash St ST. 13-57 WARD)

2-FULL NAME William Martin

(a) RESIDENCE NO. 3642 Ash St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Martin

6 DATE OF BIRTH (month, day, and year) June 14 1873

7 AGE Years	Months	Days	If LESS than 1 day....hrs. or....min.
56.	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md.
(State or country)

PARENTS

10 NAME OF FATHER Charles W. Martin

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Dora Martin
(Address) 3642 Ash St.

15 Filed ....., 19.. HAMPSON JONES, M. D. Registrar

No. 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan ....., 1920, to June 8, 1930,

that I last saw him alive on June 8, 1930,

and that death occurred, on the date stated above, at 8 20 P.m.

The CAUSE OF DEATH* was as follows:

Bronchial asthma

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral regurgitation Heart.

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) H. J. Strickler M. D.

June 8 1930 (Address) 632 Forrest

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Woodlawn

DATE OF BURIAL June 11 1930

20 UNDERTAKER Chesworth Bros

ADDRESS 3605 Eastern Ave

Note—Is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 57913

CERTIFICATE OF DEATH

REGISTERED NO. E 57913

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4682 Falls Rd ST. 28-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Bolden

(a) RESIDENCE NO. 4682 Falls Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Oct 6 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Martha Bolden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Martha Bolden

(Address) 4682 Falls Rd

15 Filed June 10 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1930, to June 8, 1930, that I last saw him alive on June 8, 1930 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Primary)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Cassard, M. D.

, 19 (Address) 153 Dodge

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 6/10 1930

20 UNDERTAKER Samuel F. Hemsley

ADDRESS 1778 McCulloh

Spec.—1-30—M. & T.—250 Blks.

E 57914

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57914

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 N. Calhoun St. 16-23 WARD)

2-FULL NAME John W. Smallwood

(a) RESIDENCE NO. 1019 N. Calhoun ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	M

5a If married, widowed, or divorced HUSBAND of ~~or WIFE~~ of Bernice Smallwood

6 DATE OF BIRTH (month, day, and year) Sept 17 - 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) P. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John Smallwood

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Addie Ballard

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Addie Johnson

(Address) 1019 N. Calhoun St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6 - 30

17 I HEREBY CERTIFY, That I attended deceased from 6/2, 1930, to 6/6, 1930, that I last saw h[illegible] alive on 6/6 - 1930, and that death occurred, on the date stated above, at 1:20 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Thrombosis

2

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Benj R Lantz M. D.

6/6, 1930 (Address) 2129 E. [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Elm

DATE OF BURIAL 6-11-1930

UNDERTAKER Sam'l W. Chase & Sons

ADDRESS 1400 Mosher

[illegible] 1930 SAM'L JOHN JONES [illegible]

NOTE—It is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57915

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1404 W. Lanvale St., 16-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Smothers

(a) RESIDENCE NO. 1404 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Hill

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Robert Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Robert Hill

(Address) 1404 W. Lanvale

15 FILED JUN 10 1930 HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9/30

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1930, to June 9, 1930, that I last saw her alive on June 8, 1930, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Degeneration

(duration) yrs. 2 mos 2 ds.

CONTRIBUTORY (Secondary) ✓ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) R. N. Dalcher M. D.

6/9, 1930 (Address) 1400 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reams Va

DATE OF BURIAL June 12th 30

20 UNDERTAKER Sam'l N. Chase Wm

ADDRESS 1400 Washington

IMPORTANT. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57916 ✓E 57916

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH Boulevard apts REGISTERED NO.

CITY OF BALTIMORE: (No. 101 East 32 Street St. 17-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Wagner

(a) RESIDENCE. No. 101 East 32 Street ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 4 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Miller Wagner

6 DATE OF BIRTH (month, day, and year) Jan 24th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 71

(b) General nature of Industry, business, or establishment in which employed (or employer) Insurance Agent

(c) Name of employer National Liberty

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ~~Louisa Hertent~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Lillie Wagner
(Address) 101 East 32 Street

15 Filed JUN 10 1930 19 C. HARRISON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from April 15th, 1930, to June 9th, 1930, that I last saw h.~~im~~ alive on June 9th, 1930, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows: Standard

Carcinoma Longus

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Murray, M. D.

, 19 (Address) 5102 W. Fremont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	6/12/1930
20 UNDERTAKER	ADDRESS
Sm. Huber & Son	2543 Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57917

CERTIFICATE OF DEATH

49 ✓ E 57917

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 Woodlawn Rd. ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Henry Buck

(a) RESIDENCE NO. Alston Apts. ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Warfield Buck

6 DATE OF BIRTH (month, day, and year) March 9 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Member of the firm

(b) General nature of industry, business, or establishment in which employed (or employer) Riggs Rosemeade & Stanley

(c) Name of employer

9 BIRTHPLACE (city or town) Wilmington

(State or country) Delaware

PARENTS

10 NAME OF FATHER Dr Chas. E. Buck

11 BIRTHPLACE OF FATHER (city or town) Wilmington

(State or country) Delaware

12 MAIDEN NAME OF MOTHER Eleanor Stratton

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country) Delaware

14 Informant Mrs Sallie W Buck (wife)

(Address) Alston Apts. City

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1929, to June 8th, 1930, that I last saw h. alive on June 8th, 1930 and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Chronic Interstitial Nephritis

Coma

a secondary

to (duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Tumor (duration) 2 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X rays & ophthalmic test Eye

(Signed) Jefferson Buck, M. D.

1930 (Address) 5 Club Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill Cemetery — DATE OF BURIAL: June 10 1930

20 UNDERTAKER: Lewis H. Hoover Company — ADDRESS: Baltimore

Important: See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57918 | 129 VE 57918

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Baltimore City Hospitals Ward)

2-FULL NAME James Gittings Butler

(a) RESIDENCE NO. 1022 Edmondson Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily Butler

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Own
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N. C.

PARENTS

10 NAME OF FATHER Arnold Butler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Elvira Parker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Mrs. E. Butler
(Address) 1022 Edmondson Ave.

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9- 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ...yrs. 3 mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zollert, M. D.

6/10. 1930. (Address) 2736 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clinton N. C.

DATE OF BURIAL 6/11/1930

20 UNDERTAKER Mrs. Geo. H. Kellam

ADDRESS 1631 Division St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 57919

HEALTH DEPARTMENT—CITY OF BALTIMORE

24-001

E 57919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Johns Hopkins Hospital 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John B. Bowen.

(a) RESIDENCE NO. 3223 Normount Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Octavia L. Bowen.

6 DATE OF BIRTH (month, day, and year) May 5. 1860.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	70.	1	4.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher. 013

(b) General nature of industry, business, or establishment in which employed (or employer) Meat cutter

(c) Name of employer ?

9 BIRTHPLACE (city or town)

(State or country) Harford - County Md.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown.

14 Informant Clifton R. Bowen.

(Address) 407 Furrow St.

15 Filed JN 10 1930. G. Hamson Jones M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/8/30.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Watkins M. D. (Coroner)

6/10/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ebenezer Cemetery. Chase, Md. Date of Burial 6/11/30

20 UNDERTAKER F.B.Wippert. ADDRESS 1850 W. Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57920

CERTIFICATE OF DEATH

31 ✓ E 57920

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 808 W Oliend ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Ellen Waters

(a) RESIDENCE NO. 808 W. Oliend ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 7 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory

(b) General nature of industry, business, or establishment in which employed (or employer) cap factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Frederick Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Jennie Stews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jennie Waters
(Address) 808 W. Oliend St

15 Filed UN 10 1930 HAMILTON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/8/30

17 I HEREBY CERTIFY, That I attended deceased from 5/31/30, to 6/8/1930, that I last saw h... alive on 6/8/1930, and that death occurred, on the date stated above, at 10:30 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Apx (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Pemurent Bronchitis (duration) abt yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical-microscopical

(Signed) Jno Bunker, M. D.

6/9/30, 19 (Address) 908 Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	June 12, 1930
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 322 N Schroeder St

Instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57921

90 E 57921

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St. 18-16 WARD)

2-FULL NAME Cecelia Dedmon

(a) RESIDENCE No. 105 N. Schroeder WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred cents mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Dedmon

6 DATE OF BIRTH (month, day, and year) July 4, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Gloucester Co. (State or country) Va.

PARENTS

10 NAME OF FATHER Vad Pryor

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Emmaline Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Simon Dedmon

(Address) 105 N. Schroeder St

15 JUN 10 1930 RAWSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-6-30

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to June 6, 1930, that I last saw h. alive on June 6, 1930, and that death occurred, on the date stated above, at 11 30 p m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. mos 16 da.

CONTRIBUTORY (Secondary) Mitral Insufficiency

Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	June 10, 1930
UNDERTAKER	ADDRESS 322
Mrs. Katie R. Williams	N. Schroeder St.

FROM a very important. See instructions on back of certificates. DEPARTMENT OF OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57922 — E 57922

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St. 25-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Charles L. Grund

(a) RESIDENCE No. 526 N. Queen St. Va. Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): unknow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): unknow

7 AGE: 62 Years Months Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: laborer — gdn

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: unknow

9 BIRTHPLACE (city or town) (State or country): unknow

PARENTS

10 NAME OF FATHER: unknow

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknow

12 MAIDEN NAME OF MOTHER: unknow

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknow

14 Informant: Mrs Annie Rinderhart

(Address) 47 St. Middleton St. Gettysburg Pa

15 Filed JUN 10 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-4-30 19

17

I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to June 9, 1930,

that I last saw him alive on June 9, 1930,

and that death occurred, on the date stated above, at 2:30 A m. Standard time

The CAUSE OF DEATH* was as follows: Carcinoma of neck - (Stando)

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Intestines -

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? — None —

Did an operation precede death? Yes, Date of 12-0-29

No 1-10-30

Was there an autopsy? No 2-0-30

What test confirmed diagnosis? Biopsy

(Signed) Hyman S Anderson, M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Martinsburg W Va

DATE OF BURIAL: 6/10/30

20 UNDERTAKER: George L Grund

ADDRESS: Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57923

E 57923

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 E. Chase ST. 10-14 WARD)

2-FULL NAME Margarete O'Dea

(a) RESIDENCE NO. 707 E. Chase ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael V. O'Dea

6 DATE OF BIRTH (month, day, and year) March 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	72	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Ireland (State or country)

PARENTS

10 NAME OF FATHER Dominick Welby

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Mann

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Ireland

14 Informant Miss Theresa O'Dea

(Address) 924 E. Eager St.

Filed JUN 10 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to June 7, 1930.

that I last saw her alive on June 7, 1930,

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Coma

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

6/9/30 (Signed) Alfred Gogl, M. D.

(Address) 709 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 11 1930

20 UNDERTAKER Elmer W. Conklin ADDRESS 824 E Eager

PRINT very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 57924

HEALTH DEPARTMENT—CITY OF BALTIMORE

177 E 57924

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. West Balto Gen Hosp Ward) 16-69

2-FULL NAME Harry C. Smith

(a) RESIDENCE NO. 2376 Edgewood Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida B. Smith

6 DATE OF BIRTH (month, day, and year): Feb 21-1861

7 AGE: Years 68 | Months 7 | Days 17 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md

PARENTS

10 NAME OF FATHER: Henry C. Smith Sr

11 BIRTHPLACE OF FATHER (city or town): Balto
(State or country): Md

12 MAIDEN NAME OF MOTHER: Olga Tuska

13 BIRTHPLACE OF MOTHER (city or town): Balto
(State or country): Md

14 Informant: Mrs Joseph Abbott
(Address): 2376 Edgewood

Filed JUN 10 1930 C. MARLTON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest) autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart
Bichloride Mercury

(duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Edward Smith, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem

DATE OF BURIAL: 6/10 1930

UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 57925

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57925

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 27-44 (WARD).

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Webster

(a) RESIDENCE NO. 3103 Weaver Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 14, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	4	25-24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Everett Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denver Col.

12 MAIDEN NAME OF MOTHER Lillian Hush

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs. Everett Webster

(Address) 3103 Weaver Ave

C. MADISON JONES

Filed JUN 10 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 8, 1930, that I last saw him alive on June 8, 1930 and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of June 6-1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Mynon G. Lee, M. D.

6/9, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL M. P. Parkwood — DATE OF BURIAL June 10th 1930

20 UNDERTAKER Philip Herring — ADDRESS 2016 Orleans St

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57926

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57926

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5709 Belair Rd. S. 26-42 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgianna Belaudy

(a) RESIDENCE NO. 5709 Belair Rd. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 94 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel W. S. Belaudy

6 DATE OF BIRTH (month, day, and year) May 6/1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER George Meatee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER — May

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Samuel W. S. Belaudy (Address) 5709 Belair Rd

15 Filed JUN 10 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9/30

17 I HEREBY CERTIFY, That I attended deceased from June 2d, 1930, to June 9th, 1930

that I last saw her alive on June 8th, 1930

and that death occurred, on the date stated above, at 3 35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchopneumonia

Nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory

(Signed) L. L. Gordy, M. D.

6-9, 1930 (Address) Harford & Overland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL June 11 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Eutaw St

FRONT Very Important! See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57927

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57927

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hosp

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 13-59 ST.) (WARD)

2-FULL NAME Sarah Ribyat

(a) RESIDENCE NO. 2910 Parkwood ST., WARD Utica N.Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. da. How long in U. S., if of foreign birth? 22 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Divorced

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Hyman Ribyat

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham V. Kirschowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Flora —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1439 E Baltimore St.

15 Filed 6-10-30, 19 ... A. POUR DUVAL, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9-30

17 I HEREBY CERTIFY, That I attended deceased from 4-16, 19 30, to 6-9, 19 30,

that I last saw h.s.v alive on 6-9, 19 30,

and that death occurred, on the date stated above, at 2:45 p.m.

The CAUSE OF DEATH* was as follows:

Ca. of Oesoph + Stomach

(duration) ? yrs. mos da.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5/10/30

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) Hyman, M. D.

19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holmes Woods Road — DATE OF BURIAL 6-10- 1930

20 UNDERTAKER Jack Lewis, 1439 E Balto St — ADDRESS

FROM A VERY Important. See instructions on back of certificates. DEPARTMENT OF OCCUPA-

Spec.—1-30—M. & T.—250 Blks.

E 57928

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57928

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 N. Pulaski ST. 15-68 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Berman

(a) RESIDENCE NO. 1500 N. Pulaski ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosie Berman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Juda Berman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Martha —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1439 E. Baltimore St.

D 1830 C. HARRISON JONES, M. D., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10-1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 5, 1930, to June 10, 1930, that I last saw him alive on June 9, 1930, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Senile gangrene of feet

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ✓

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas F Block, M. D.

June 10, 1930 (Address) 20 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	6/10/30

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

IMPORTANT. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57929

CERTIFICATE OF DEATH

129 E 57929

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 706 S. Charles St. 22-31 Ward)

2-FULL NAME William Johnson. (C)

(a) RESIDENCE NO. 706 S. Charles St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Do not know

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	41	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman S/S Atlanta.
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Hattie Askew. (C)
(Address) 106 Spencer St. Pourtsmouth. V.

15 Filed ..., 19..
C. HILLSON JONES, M. D.
Registrar

10 10 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.
Uraemia.

(duration) ..yrs. ..mos. ..da.

CONTRIBUTORY
(Secondary)

(duration) ..yrs. ..mos. ..da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible] M. D.

6/10, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct — DATE OF BURIAL June 10 1930

20 UNDERTAKER S. L. Brownd's Son — ADDRESS 1081 N. Wendy

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-22—A Co.—100 Bks.

E 57930

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

8/E 57930

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 715 N. Carlton St., 18-16 Ward)

2-FULL NAME Clement B. Jones

(a) RESIDENCE NO. 912 W. Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliza

6 DATE OF BIRTH (month, day and year): 1871

7 AGE: Years 59 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Minister
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

018

9 BIRTHPLACE (city or town): Va
(State or country)

PARENTS

10 NAME OF FATHER: Henry Jones

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: Annie Williams

13 BIRTHPLACE OF MOTHER (city or town):
(State or country)

14 Informant: Clem Jones
(Address) 912 W. Baltimore St.

15 Filed ..... 19.....

10 1930

HAMILTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris
(duration) Sudden

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) H. Hamilton Jones, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: 6-11 1930

20 UNDERTAKER: Daniel Easton

ADDRESS: Balto

IMPORTANT.—Questions must be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 57931 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57931

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 9-46 REGISTERED NO. 57

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Nevell

(a) RESIDENCE NO. 638 Aull St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1869 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Tom Perkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Emma ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Records of (Address) Balto. City Hosp. M. D.

JUN 10 1930

Filed ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8-30

17 I HEREBY CERTIFY, That I attended deceased from 10-29-29, 19..., to 6-8-30, 19..., that I last saw h.er alive on 6-8-30, 19..., and that death occurred, on the date stated above, at 9:50 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

More than (duration) ... yrs. 10 mos ... ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Lab. Exam. Urinary.

(Signed) Paul Padget, M. D.

6-9, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem DATE OF BURIAL June 11 1930

UNDERTAKER Robert Williams ADDRESS 1515 McElderry St

HON is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 3 6 93
E 57932

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57932

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-13 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Zawadsky

(a) RESIDENCE NO. 947 N. Dunbar ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Frank Zawadsky

6 DATE OF BIRTH (month, day, and year) July 26-1893

7 AGE: Years 36 | Months 10 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS
10 NAME OF FATHER Frank Voit
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Lottie Lang
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9-1930

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1930, to June 9, 1930, that I last saw her alive on June 9, 19..., and that death occurred, on the date stated above, at 10 35 A m.

The CAUSE OF DEATH* was as follows:

a Pulmonary Embolism

(duration) 15 minutes

CONTRIBUTORY (Secondary) Hypostatic thrombophlebitis.
Duration (duration) probably over 2 weeks.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of 5-12-30

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Raymond T. Vanier, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: June 11 1930

20 UNDERTAKER: Frank Bracken — ADDRESS: 1906 Eastern Ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 57933 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57933

CERTIFICATE OF DEATH.

89

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2005 Eastern Ave ST. 9-4 (WARD)

2-FULL NAME Henry Schmidt

(a) RESIDENCE NO. 2005 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of Anne Schmidt

6 DATE OF BIRTH (month, day, and year) June 13 - 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Building

(c) Name of employer Box Factory

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotta Klingenfuss

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant Anne Schmidt (Address) 2005 Eastern Ave.

15 June 10 1930 C. HAMILTON JONES, M. D. Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9/30

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1930 to June 9, 1930 that I last saw h[illegible] alive on June 6, 1930 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Coronary thrombosis (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Nathan Kellgood, M. D.

June 10, 1930 (Address) 11 No. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul Cemetery — DATE OF BURIAL June 11, 1930.

20 UNDERTAKER Mrs. Mrs. John M. Teufel & Son — ADDRESS 801 N. Fayette

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 57934

CERTIFICATE OF DEATH

49 E. 57934

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 E. 40th St. 13-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma F. Ashwood

(a) RESIDENCE NO. 1107 E. 40th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Ashwood.

6 DATE OF BIRTH (month, day, and year) July 2 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	61	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer at home

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Frank L. Sutton

11 BIRTHPLACE OF FATHER (city or town) Cumberland (State or country) Md.

12 MAIDEN NAME OF MOTHER Georgianna Jones

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Edward F. Ashwood.

(Address) 1107 E. 40th St.

15 JUN 10 1930 C. HAMILTON JONES, M. D. Registrar

Important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10/30

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to June 10, 1930, that I last saw h[illegible] alive on June 10 1930 and that death occurred, on the date stated above, at 11:15 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Head Pancreas

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Obstructive Icterus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) J. M. Hilsdale, M. D.

6/12 1930 (Address) 848 W. 36th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery. DATE OF BURIAL June 12/1930

20 UNDERTAKER Walter Davis 3207 ADDRESS Paine St.

1-30—M. & T.—100 B—50L

Murray

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57[illegible]5

90

E 57[illegible]5

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 542 N. Lakewood Ave ST., 7-10 WARD)

2-FULL NAME Elijah Murray

(a) RESIDENCE NO 542 N. Lakewood Avr ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary C. murray

6 DATE OF BIRTH (month, day, and year) May 14/1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	0	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocery Store
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Cruze

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elijah Murray (son)
(Address) 542 N. Lakewood Ave

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Chr Myocarditis

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. F. A. Cover, M. D.
Coroner

6/10/1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	June 12 1930
20 UNDERTAKER	ADDRESS
Wm. C. Black	927 N. Broadway

IT IS VERY IMPORTANT. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 57936 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57936

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 24-34 WARD (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Higgins

(a) RESIDENCE NO. 503 E. Barney ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Michael Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Busch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Baltimore City Hospitals

15 Filed JUN 1930 19 C. HAMPSON HIGGS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-9-30

17 I HEREBY CERTIFY, That I attended deceased from 6-2-30, 19..., to 6-9-30, 19...,

that I last saw him alive on 6-9-30, 19...,

and that death occurred, on the date stated above, at 7:45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder (over)

(duration) UNKNOWN. yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis & Pyelitis

(duration) UNKNOWN. yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

6-10, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL 6/12/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

(Crisafulli)

E 57937

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57937

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ..... ST. 8-16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bartolo Crisafulli

(a) RESIDENCE NO. 1969 N. Patterson Park Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Louis

6 DATE OF BIRTH (month, day, and year) Aug 2nd 1880

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Crisafulli

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Katharine Allis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mr Louis Crisafulli

(Address) 1969 N. Patterson Park Ave

15 Filed ..... By ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/9/30

17

I HEREBY CERTIFY, That I attended deceased from 5/31/30, 19..., to 6/9/30, 19..., that I last saw h~~im~~alive on 6/9/30, 19..., and that death occurred, on the date stated above, at 6 1/2 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 1 yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Harold Jensen, M. D.

6/9/30 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 6/12/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57938

E 57938

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins "ospital ST. 16-37 WARD)

2-FULL NAME Aristoa (Mary) Karavedas

(a) RESIDENCE NO 4702 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alex. Karavedas

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Alex. Karavedas
(Address) 4702 Eastern Ave

15 Filed 6/10/30 192 C. HAMPSON JONES, M. D. Registrar

0 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Ruptured uterus-compound presentation.
(in "ospital few hrs)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of June 10/30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Potter, M. D.
Coroner

6/10/30 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 6/11/30. 19

20 UNDERTAKER George J. Potts. Inc

ADDRESS 1735 Harford Ave

FOR IS VERY important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57939

CERTIFICATE OF DEATH

74-681 E 57939

E 57939

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital 18-16 Ward)

2-FULL NAME Cornelia Burton

(a) RESIDENCE NO. 906 W. Mulberry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry Burton

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Thomas Gross

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Nealy Savage

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Henry Burton
(Address) 906 W Mulberry St

Filed 6 11 1930 19.. [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feltz, M. D.

6/10, 1930. (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calary Cemtery — DATE OF BURIAL 6/12 1930

20 UNDERTAKER Walter B. Suggs — ADDRESS 139 W. Hamburg St

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 57840

CERTIFICATE OF DEATH

E 57840

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2610 St. Paul Street ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Allen Lincoln Smith

(a) RESIDENCE NO. 2610 St. Paul Street ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel K. Smith

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerville, Mass.

PARENTS

10 NAME OF FATHER Samuel A. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass. Maine

12 MAIDEN NAME OF MOTHER Emma Coomey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Mable K. Smith

(Address) 2610 St. Paul Street

15 FILED JUN 11 1930 A. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1930. to June 8, 1930.

that I last saw him alive on June 8, 1930

and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Maurice L. Shaner M. D.

6/10, 1930 (Address) 3300 N. Dolfield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	June 11, 1930
20 UNDERTAKER E. Leroy Stiffler, Inc.	ADDRESS 125 E. North ave.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57941

CERTIFICATE OF DEATH

90 ✓

E 57941

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2320 Penna Ave 12-59 WARD)

2—FULL NAME Estelle Jones

(a) RESIDENCE NO. 2320 Penna Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Parker

6 DATE OF BIRTH (month, day, and year): July 1898

7 AGE: Years 31 | Months 11 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Corey Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carolina

12 MAIDEN NAME OF MOTHER: Dunetta Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Dunetta Myers

(Address) 2320 Penna Ave

15 Filed: JAN 1 1930 19 Registrar: Reed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 / 30

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1930, to June 10, 1930, that I last saw her alive on June 10, 1930 and that death occurred, on the date stated above, at 11 30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 6 ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Fry, M. D.

6/10, 1930 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: June 12 19 30

20 UNDERTAKER: Lawrence Goodrich

ADDRESS: 2048 Carollton Ave

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 57942

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57942

CERTIFICATE OF DEATH X

101-001

REGISTERED NO. 291

1—PLACE OF DEATH U. S. Marine Hospital, Baltimore, Maryland.

CITY OF BALTIMORE: (No. 12-51 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence Taylor

(a) RESIDENCE NO. 11-1/2 College Ave., Annapolis, Md. WARD

(Usual place of abode) (If non-resident give rity or town and State)

Length of residence in rity or town where death ocrurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lollie Taylor

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or partirular kind of work Cook

(b) General nature of industry, business, or establishment in which rinployed (or employer) Seaman

(c) Name of employer Str. Gov. Emerson C. Harrison Washington, D.C.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Taylor

11 BIRTHPLACE OF FATHER (city or town) Richmond, (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Eliza Pennelton

13 BIRTHPLACE OF MOTHER (rity or town) Md. (State or country)

14 Informant U. S. Marine Hospital Records (Address) Baltimore, Maryland.

15 Filed May 14, 1930 John Howard Lee, REGISTRAR

1 17311

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to May 12, 1930, that I last saw him alive on May 11, 1930 and that death ocrurred, on the date stated above, at four a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, lobar, entire lung

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical and laboratory

(Signed) Ralph E. Porter, M. D.

Ralph E. Porter

-12, 1930 (Address) U.S. Marine Hospital, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL McDaniel Md

DATE OF BURIAL May 14 193

20 UNDERTAKER J. N. Marshall

ADDRESS St Michaels

Spec.—1-30—M. & T.—250 Blks.

E 57043

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

CERTIFICATE OF DEATH.

E 57043

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Lewis

(a) RESIDENCE NO. 1208 St. Matthews ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Edward Lewis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Glouster

(State or country) Va.

PARENTS

10 NAME OF FATHER George Jackson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Jane ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Records of

(Address) Balto. City Hosp.

Filed UN 1 1 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8-30

17 I HEREBY CERTIFY, That I attended deceased from 3-31-30, 19..., to 6-8-30, 19...

that I last saw her alive on 6-8-30, 19...

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Syphilis of Central Nervous system; Erb's Spastic paraplegia (duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Septicaemia from decubitus ulcers (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. Wasserman.

(Signed) Pauline Padgett, M. D.

6-9, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glouster Va.

DATE OF BURIAL 6-11 1930

20 UNDERTAKER Byron Wright

ADDRESS 1218 McElderry St.

Instructions: See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Thomas T. Watson

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 57944

57944

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1105 W. Saratoga St. WARD 16-Wa)

2-FULL NAME Thomas T Watson

(a) RESIDENCE NO. 1105 W Saratoga ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~
HUSBAND of
~~(or) WIFE of~~ Mary B

6 DATE OF BIRTH (month, day, and year) July 21st 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Scale Mech

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer Chesapeake S.S. Co Balto

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Robert Watson

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Nancy Oliver

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs Mary Watson
(Address) 1105 W. Saratoga St

15 Filed JUN 11 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1930

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to June 10, 1930, that I last saw h/m alive on June 9, 1930, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H Grohane M. D.

June 10 1930 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL 6/13 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57945

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 57945

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

REGISTERED NO. 27-44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

2-FULL NAME Virginia Barger

(a) RESIDENCE NO. 2700 Overland Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 17, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry Barger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Virginia E. Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry Barger

(Address) 2700 Overland Ave

15 Filed ..... 19 .....

1-1-1930 BALTIMORE CITY, MD.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11-1930

17

I HEREBY CERTIFY, That I attended deceased from May 30 -, 1930, to June 11 -, 1930,

that I last saw her alive on June 11 -, 1930,

and that death occurred, on the date stated above, at 12:45 A m.

The CAUSE OF DEATH* was as follows:

Empyema - Left side following pneumonia

(duration) ..... yrs. ..... mos 16 ds.

CONTRIBUTORY (Secondary) Meningitis -

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes (thoracotomy) Date of May 31-1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs + symptoms

(Signed) Walter B. Goodhue, M. D.

June 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 6/16 1930

20 UNDERTAKER Jno Cook

ADDRESS 1217 E Pratt St

FROM If very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57946

188-103

CERTIFICATE OF DEATH

E 57946

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hosp St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

REGISTERED NO.

2-FULL NAME Virginia E Clemmens

(a) RESIDENCE NO. 1404 W. Lexington St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 9 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12 1850

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	79	9	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Martha E Baker
(Address) 1404 W. Lexington St

15 Filed 6-11 1930 H. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Struck & knocked down by a moving auto at unknown time

(a) Fract. Skull (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Laynton & Monte

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? H. Clemmens

(Signed) H. Hanson, M. D.

6 10, 1930 (Address) 2931 W. Eldery

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 12 1930
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

S 57047 — 25 1947

CERTIFICATE OF DEATH.

REGISTERED NO. 91

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3814 Woodhaven St. 15 — 16 WARD)

2-FULL NAME Matilda Mann

(a) RESIDENCE. No. 3814 Woodhaven ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George W Mann

6 DATE OF BIRTH (month, day, and year): Apr 19 1855

7 AGE: Years 75 Months 1 Days 9 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Levi Markel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Informant: W. L. Dorsey
(Address) # 2315 Eva St S.E. Washington D.C.

15 Filed ..... 19.. C. HAMPSON JONES Registrar

By ..... Asst.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 1930

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1930, to June 10, 1930, that I last saw h.. alive on June 10, 1930, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Gangrene of left foot

(duration) 2 yrs. mos. 25 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Thos. Lee Yeldell M. D.

, 19 (Address) 3913 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: June 13 1930

20 UNDERTAKER: W. J. Buckner Sons ADDRESS: North & Pa

TION is very important. See instructions on back of certificates.

OCCUPA-

Spec.—1-12-23—M&T—500 Bks.

E 57948

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57948

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1736 Broadway ST. 25-76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Williams infant

(a) RESIDENCE NO. 1736 Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or min.: 33

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Eddie Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Ella Mae Bryant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant: Eddie Williams

(Address)

15 Filed: 1-1-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10— 1930

17 I HEREBY CERTIFY, That I attended deceased from June 10— 1930 to Jun 10 1930, that I last saw h[illegible] alive on June 10— 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Congenital debility (Premature)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Fiske Sylvester, M. D.

1930 (Address) 2034 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: JUN 1 1930

20 UNDERTAKER: Commissioner Health.

ADDRESS

FROM is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57949 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57949

CERTIFICATE OF DEATH.

3 V

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (NO. 5-6 ST. WARD)

2-FULL NAME Willie Mae Edmunds

(a) RESIDENCE NO. 909 Low st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Wilson Edmunds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Lonie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address)

15 Filed 6-11 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to June 10, 1930,

that I last saw her alive on June 10, 1930,

and that death occurred, on the date stated above, at 3.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas. Shands Jr. M. D.

6-11 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem. DATE OF BURIAL June 13 1930

20 UNDERTAKER Thos. J. & Locke ADDRESS 1302 Pacy

Spec.—1-12-23—M&T—500 Bks.

E 57950 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57950

CERTIFICATE OF DEATH.

101-04

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Penna Ave ST., 17-24 WARD)

2-FULL NAME Winton McClain Robinson

(a) RESIDENCE NO. 1119 Penna Ave ST., 14 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/28/29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	2	14 13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER David Robinson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Bertha Tabb

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Cape Charles Va

14 Informant Bertha Robinson
(Address) 1119 Penna ave.

15 Filed 1 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/11/1930

17 I HEREBY CERTIFY, That I attended deceased from 6/10/1930, to 6/11/1930, that I last saw him alive on 6/11/1930, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema
Cardiac & Respiratory failure
(duration) .... yrs. .... mos 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia
(duration) .... yrs. .... mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical & Autopsy

(Signed) Orrin H Bishop M. D.

, 19 (Address) 709 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 6-11 1930

20 UNDERTAKER David A Carter

ADDRESS 716 Druid

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—350 Blks.

E 57951 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57951

CERTIFICATE OF DEATH.

X 99-002

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1-13 ST. WARD)

2-FULL NAME Meyer Oppenheim

(a) RESIDENCE NO. Mt. Pleasant Sanatorium, Pikesville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Sadye Oppenheimer

6 DATE OF BIRTH (month, day, and year): Dec 13th 1868

7 AGE: Years 61 | Months 5 | Days 28 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Shoes

(c) Name of employer: B Berman

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Abraham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Simmons Mushaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Jos Oppenheimer

(Address): 1712 Ellamont Rd

15 Filed JAN 1 1930 C. HAMILTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/10/30

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1930, to June 10, 1930, that I last saw him alive on June 10, 1930, and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral Suppurative Bronchiectasis

over

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary): Lung Abscess

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) Milton B. Kirsh X-Ray, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship

DATE OF BURIAL: 6/12 1930

20 UNDERTAKER: J. Ahrens Co

ADDRESS: 2432 Reisterstown Rd

FROM IF VERY IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 57952

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57952

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 118 S. Fulton Ave (St.) (Ward) 24

2-FULL NAME Margaret L. Roddy

(a) RESIDENCE NO. 118 S. Fulton Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon B. Roddy

6 DATE OF BIRTH (month, day, and year) Oct. 4 - 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	92	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Housework At home

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co. (State or country) Md.

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Hovis

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Mrs. Charles W. Schultz

(Address) 118 S. Fulton Ave.

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

By .....

1 1 7230

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to June 10, 1930.

that I last saw h[illegible] alive on June 9, 1930

and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephro-
cordatis

(duration) 2 yrs. m[illegible] ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James R. Reisinger M. D.

6/10 19 30 (Address) 1729 E. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Cathedral Cemetery — DATE OF BURIAL June 13 1930

20 UNDERTAKER George L. Schnaul — ADDRESS 1101 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 57953

HEALTH DEPARTMENT—CITY OF BALTIMORE 199

E 57953

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Balto Hosp St. 25-75 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Nerlth

(a) RESIDENCE NO 642 Patapsco Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Winkeling

6 DATE OF BIRTH (month, day, and year) About 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Ohio
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Ernest Nerlth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Schuler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Nerlth

(Address) 642 Patapsco Av

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE-OF DEATH* was as follows:
Auto in which he was a rider struck pole throwing him out then running over him
Hour D (duration) yrs. mos. da.
CONTRIBUTORY (Secondary) Shock, Lung. C. C. Fract Ribs Right side
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Emerson Branch Amol Pls Ry
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) J. J. France, M. D. Coroner
6/10 1930 (Address) 2939 W. Eldern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 6/13 1930

20 UNDERTAKER J. J. Fahey Howard — ADDRESS 131 S Eutaw

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57954

CERTIFICATE OF DEATH.

43 E 57954

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 24-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Schneider

(a) RESIDENCE NO. 1438 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of Anna Schneider

6 DATE OF BIRTH (month, day, and year) —/64

7 AGE: Years 66 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer 086

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hohmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Chas. Schneider 1438 Eutaw St

15 Filed JUN 11 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/9/30

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1930, to June 9, 1930, that I last saw him alive on June 9, 1930, and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Lower Alveolar Process + Buccal Cavity with Metastases to Submaxillary Glands (duration) yrs. 6 mos da.

CONTRIBUTORY (Secondary) Auricular Fibrillation, Cardiac Decompensation yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes (Neck Dissection) Date of 6/6/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Operative

(Signed) Leroy S. Peck, M. D.

6/9 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loud Redeemer | DATE OF BURIAL 6/12 1930

20 UNDERTAKER J. F. Fahey Sons | ADDRESS 1318 Eutaw St.

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57955

CERTIFICATE OF DEATH

X 199 E 57955

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Union Memorial Hospital St., Ward)

2-FULL NAME Patrick J. Langdon

(a) RESIDENCE NO. Edgewood, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30, 1906

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
24	2	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Soldier
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer U. S. Army

9 BIRTHPLACE (city or town)
(State or country) New York City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant U. S. Army Records
(Address) Edgewood, Md.

15 Filed JUN 11 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture base of skull

Cause of fractured Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-7-30

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) John F. Morrissey, M. D.

6/11 1930 (Address) 2532 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stapleton, Staten Island, N.Y. DATE OF BURIAL June 11, 1930

20 UNDERTAKER H. K. McComas ADDRESS Abingdon, Md.

OF DEATH in plain terms, so that it may be properly classified. Use statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 57956

REGISTERED NO. 57956

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1404 Forge ave St., 27th Ward

2-FULL NAME Katie Thompson

(a) RESIDENCE NO. 1404 Forge ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	White	Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE~~) of Howard.

6 DATE OF BIRTH (month, day, and year) Jan 21 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	33	8	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer At Home.

9 BIRTHPLACE (city or town)
(State or country) Ga

PARENTS

10 NAME OF FATHER David Thompson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ga

12 MAIDEN NAME OF MOTHER Lucy Thompson

13 BIRTHPLACE OF MOTHER (city or town) Ga
(State or country)

14 Informant Louise Thompson
(Address) 1404 Forge ave

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

6/11 1930 (Address) 763 Poland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mary [illegible]

DATE OF BURIAL 6/12 1930

20 UNDERTAKER [illegible]

ADDRESS [illegible] St. Paul St.

Spec.—1-30—M. & T.—250 Bks.

E 57952 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57957

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 861 W. 36th St ST. 13-52 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Wilson

(a) RESIDENCE NO. 861 W. 36th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. W. Wilson

6 DATE OF BIRTH (month, day, and year) Nov 25/1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Archibald Lindsay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Joyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charlotte Wilson (Address) 861 W. 36th St

15 Filed 1 1930, 19 R. E. H Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9/30

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to June 9, 1930, that I last saw h alive on June 8 1930 and that death occurred, on the date stated above, at 8 3/4 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) [illegible], M. D.

6/11, 1930 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dallo Cem

DATE OF BURIAL June 12 1930

20 UNDERTAKER Philip Sewing

ADDRESS 2616 Eutaw St

C. BAMPTON JONES, M.D.

TION is very important See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 57958

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57958

CERTIFICATE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 Tunbridge Rd ST. 7-48 (WARD)

2-FULL NAME Florence Martin

(a) RESIDENCE NO 603 Tunbridge Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17/1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	3	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto. City Schools

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER George Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Kezia G. Pitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George Martin
(Address) 603 Tunbridge Rd.

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. S. Hamilton, M. D.
Coroner

6/1/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery — DATE OF BURIAL 6/12/30

20 UNDERTAKER W. E. Cook — ADDRESS 1217 E. Fayette St

FILL IN very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 57959

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 57959

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph M. Shock

(a) RESIDENCE NO 1501 N. Luzerne Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white.	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 21/1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	1	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Telegraph Operator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Western Union

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Shock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Mullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John Shock
(Address) 1501 N. Luzerne Ave

15 Filed 6-12-1930 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
(History Rheumatic Heart for years)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], Coroner, M. D.

6/11/30 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	6 14 1930

20 UNDERTAKER	ADDRESS
W. Cook	1217 St Paul St

IMPORTANT. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57960

CERTIFICATE OF DEATH

88 ✓ E 57960

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1125 Binney St. 1-3 Ward)

2-FULL NAME Pelagia Owsianiecka

(a) RESIDENCE NO. 1125 Binney St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Owsianiecka

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-work
(b) General nature of industry, business, or establishment in which employed (or employer) 631
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mr. C. Owsianiecka
(Address) 1125 Binney St.

15 1930 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9- 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Grier Fillert, M. D.

6/10, 1930. (Address) 2736 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Standish	June 12 1930
20 UNDERTAKER John N. Wilde	ADDRESS Chester

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 57961

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 57961

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1709 McCulloh St., 14-21 Ward)

2-FULL NAME Rachel E. Freeze

(a) RESIDENCE NO. 1709 McCulloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos F.

6 DATE OF BIRTH (month, day and year) Sept 16-1850

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	79	8	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Jas Scott

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Thos Tuckson
(Address) 1709 McCulloh

15 Filed ..... 19..... Registrar

1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos A. Scott M. D.

Jan 11, 19 (Address) Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chester Md.

DATE OF BURIAL 6/12/1930

20 UNDERTAKER Jno Geo H. Holland

ADDRESS 1631 Div

Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57962

CERTIFICATE OF DEATH

74002

E 57962

1-PLACE OF DEATH Jenkins Memorial Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1000 Caton Ave ST., 10-15 (WARD)

2-FULL NAME Annie Brown

(a) RESIDENCE NO. 1048 Brentwood Ave ST. WARD 10
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15

7 AGE — Years: 72 — Months: 11 — Days: 9 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Rose —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Jenkins Memorial Hosp.
(Address) 1000 Caton Ave

15 Filed JUN 12 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1930

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to June 10, 1930, that I last saw her alive on June 9, 1930, and that death occurred, on the date stated above, at 1-20 a. m.

The CAUSE OF DEATH* was as follows:

cerebral thrombosis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) George Burns, M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: June 12 1930

20 UNDERTAKER: Rita Wiedefeld

ADDRESS: 914 Fremont Ave

FROM A very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

237844

E 57963

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57963

CERTIFICATE OF DEATH.

X 49

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 7-9 WARD)

2-FULL NAME Julian Frye

(a) RESIDENCE NO. Carthage - N. Car. - WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 1925

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N - Car -

PARENTS

10 NAME OF FATHER Edward Frye

11 BIRTHPLACE OF FATHER (city or town) N. Car. - (State or country)

12 MAIDEN NAME OF MOTHER Pearl Barrett

13 BIRTHPLACE OF MOTHER (city or town) N. Car. - (State or country)

14 Informant Edward C. Frye (Address) JOHNS HOPKINS HOSPITAL Carthage N.C.

15 Filed JUN 13 1930 19 H. [illegible] JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11-30

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1930, to June 11, 1930,

that I last saw h~~im~~ alive on June 11, 1930,

and that death occurred, on the date stated above, at 4.50 p m.

The CAUSE OF DEATH* was as follows:

Brain Tumor - Malignant Glioma

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-11-30

Was there an autopsy? Yes

What test confirmed diagnosis? Ex-Eyes

(Signed) C. H. Brigg, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carthage N.C. DATE OF BURIAL June 13 1930

20 UNDERTAKER Sinclair Coble Funeral Home ADDRESS Carthage N.C.

FOR A VERY important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

Rachel S Barnitz-

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57964 gv E 57964

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33rd ST. 28-64 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ray Hecht Barnitz.

(a) RESIDENCE No. 4504 Springdale Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M. Ray Hecht Barnitz

6 DATE OF BIRTH (month, day, and year) Feb, 11 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, of establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New Orleans
(State or country) La.

PARENTS

10 NAME OF FATHER M. Alfred Simmons

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Josephine Hart

13 BIRTHPLACE OF MOTHER (city or town) Charleston
(State or country) S. C.

14 Informant Hospital Records
(Address) Union Memorial Hosp.

15 Filed JUN 12 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11/30

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to June 11, 1930, that I last saw h[illegible] alive on June 11, 1930, and that death occurred, on the date stated above, at 5 15 P m.

The CAUSE OF DEATH* was as follows: (Daylight Saving time)

Arteriosclerosis

(duration) ? yrs. ? mos ... ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis right

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? Baltimore.

Did an operation precede death? Yes Date of June 7 1930

Was there an autopsy? Yes.

What test confirmed diagnosis? Occlusion of Coronary Artery

(Signed) T Campbell Thompson, M. D.

June 11, 1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	June 14 1930
UNDERTAKER Chas. L. Whitehill Sons	ADDRESS Place Eutaw

FRONT—Very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57965

CERTIFICATE OF DEATH

31 ✓

E 57965

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 n Spring ST. 5-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Dyson

(a) RESIDENCE NO. 425 (Usual place of abode) W Spring ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Viola Dyson

6 DATE OF BIRTH (month, day, and year) 4 8 95

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....mins.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'Neill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Steven Dyson

11 BIRTHPLACE OF FATHER (city or town) (State or country) S C

12 MAIDEN NAME OF MOTHER Rosalee Dyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C

14 Informant John Green

(Address) 1725 W Spring St

15 Filed JUN 13 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11-30

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to June 11, 1930, that I last saw h alive on June 11, 1930 and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

6-11, 1930 (Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Roseland S. C.

DATE OF BURIAL June 13 1930

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1725 Washington

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE 57966

57966

CERTIFICATE OF DEATH.

REGISTERED NO. 1291

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5229 Dunmore Ave. (St.) 27-5 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Nelson

(a) RESIDENCE. NO. 5229 Dunmore Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Nelson

6 DATE OF BIRTH (month, day, and year): 18 Apr 1882

7 AGE — Years: 48 — Months: 1 — Days: 6 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self. Lancaster Co

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Columbus Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary Chinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Edna Hartman

(Address): 5229 Dunmore Ave

Filed JUN 12 1930 H. HARRISON JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 9, 1930, that I last saw her alive on June 9, 1930, and that death occurred, on the date stated above, at 6:00 a.m.

The CAUSE OF DEATH* was as follows:

Albuminuria.

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma.

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Wolfe Hall M. D.

, 19 (Address) 5912 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: June 12, 1930

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—350 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57962

E 57962

CERTIFICATE OF DEATH.

REGISTERED NO. 107-003

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (NO. 15-21 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Cohen

(a) RESIDENCE NO. 2013 Baker St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Bella Cohen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia Poland

PARENTS

10 NAME OF FATHER Abraham Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant ... (Address) 1439 Bank St.

15 HAMPSON JONES, M. D. Registrar

127230

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 11, 1930, that I last saw him alive on June 11, 1930, and that death occurred, on the date stated above, at 10:20 A m.

The CAUSE OF DEATH* was as follows:

Non tubercular abscess of lung

(duration) yrs. 1 mos gave

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Pneumotomy Date of June 11, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation

(Signed) Milton B. Tessler M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 6-12-1930

20 UNDERTAKER Jack Levine, 1439 E

ADDRESS Balto St

Note—Very Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 57968 HEALTH DEPARTMENT—CITY OF BALTIMORE E 57968

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 S. Kenwood ave ST. 1-3 WARD)

2-FULL NAME Elizabeth (Lizzie) Schehlein

(a) RESIDENCE NO. 602 S. Kenwood ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George P. Schehlein

6 DATE OF BIRTH (month, day, and year) Feb 12-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Conrad Baumschmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant John Schehlein

(Address) 602 S. Kenwood ave

15 Filed JUN 12 1930, 19 (SHOP NOT ENTERED) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10- 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10, 19 30, to June 10, 19 30,

that I last saw h alive on 11 9, 19,

and that death occurred, on the date stated above, at 6.35 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Edw. L. Greer, M. D.

6/10/30 (Address) 408 S Pat Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL June 13 1930

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager st

NOTE—Very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—200 Blks.

E 57969 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 57969

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St. 14-20 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Frank.

RESIDENCE NO. Marlborough Apts. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Sam'l. Frank

6 DATE OF BIRTH (month, day, and year) Oct. 4 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Mandelbaum

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Henriette Hartman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Mr. N. Frank
(Address) 2 Marlborough Apts.

15 Filed ....., 19 .....
By ..... Registrar

E. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/12/30

17 I HEREBY CERTIFY, That I attended deceased from 6/2, 1930, to 6/12, 1930, that I last saw h.r alive on 6/12, 1930, and that death occurred, on the date stated above, at 12:05 A m.

The CAUSE OF DEATH* was as follows:

Acute Diverticulitis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes. Date of 6/2/30

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam. Operation.

(Signed) A. A. Silver, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 6/13/1930

20 UNDERTAKER Hurd Sondheim & Son

ADDRESS 1902 Eutaw Place

NOTE—Very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

43V

E 57970

B 57970

REGISTERED NO. 70-21

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hosp. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma L. Roettger

(a) RESIDENCE NO. 1912 W. Fayette St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 5 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Wm J. Roettger Sr

6 DATE OF BIRTH (month, day, and year) Dec 11th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. Hildebrandt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Wilhelmina Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm J. Roettger Sr

(Address) 1912 W. Fayette St

15 FILED [illegible] NAME [illegible] Registrar

JUN 12 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11/30

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to June 11, 1930.

that I last saw her alive on June 11, 1930

and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma L mouth, jaw and neck

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical picture

(Signed) Arthur Kallmann, M. D.

6/11, 1930 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 6/13/1930

20 UNDERTAKER H. S. Wyglust

ADDRESS 1850 W. Baltimore St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57971

E 57971

CERTIFICATE OF DEATH.

REGISTERED NO. 182

1-PLACE OF DEATH Prot. Episcopal Church Home

City of BALTIMORE: (No. 23rd St. Huntingdon Ave St., 42-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William N. France.

(a) RESIDENCE NO. 2121 Huntingdon Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8, 1920

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	10 9	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md

(State or country)

PARENTS

10 NAME OF FATHER Wm. France

11 BIRTHPLACE OF FATHER (city or town) md

(State or country)

12 MAIDEN NAME OF MOTHER Nellie Shugart

13 BIRTHPLACE OF MOTHER (city or town) md

(State or country)

14 Informant Wm. France

(Address) 2121 Huntingdon Ave

JUN 12 1930 C. HAMILTON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1930.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John Monaco M. D.
(Coroner)

6/11 1930 (Address) 3432 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — Date of Burial June 13, 1930

20 UNDERTAKER Thanhouser Son — ADDRESS 3615 Chestnut ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 57972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

H+E 57972

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2411 E Monument ST., 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hannah Herold

(a) RESIDENCE NO. 2411 E Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Herold

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Andrew Medenger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary [illegible]

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Derby

(Address) 2411 Monument

15 FILED DEC 1 2 1930 C. HAMILTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 30

17 I HEREBY CERTIFY, That I attended deceased from June 1 - , 1930, to June 11 - , 1930, that I last saw h[illegible] alive on June 11 - , 1930 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall-Bladder

(duration) 7 yrs. 6 mos. 11 da.

CONTRIBUTORY (Secondary) Myocarditis & Pneumonia (duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward J. Bloom, M. D.

, 19 (Address) 2266 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL June 14 1930

UNDERTAKER Fred Black Son

ADDRESS 1906 Orleans St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57973

90 ✓ E 57973

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1401 Reynolds St. St. 24-35 Ward)

2-FULL NAME Andre Gustav Johnson.

(a) RESIDENCE NO. 1401 Reynolds St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. --mos. --ds. How long in U. S., if of foreign birth? 18 yrs. --mos. --ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	57	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Sweden.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Martin Carlson.
(Address) 1401 Reynolds St.

15 Filed 2 1930 19 C. H[illegible] JONES, Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [signature] M. D.

6/6, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
JS HOPKINS HOSPITAL

DATE OF BURIAL
JUN 12 1930

UNDERTAKER

ADDRESS

Commissioner Health

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

B 57974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

59-003 ✓

151

E 57974

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Causer

(a) RESIDENCE NO. University Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 5, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) University Hospital (State or country)

PARENTS

10 NAME OF FATHER Edgar Causer

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Caddie M. Cray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Mother (Address) 415 W. Hoffman St.

15 Filed JUN 12 1930 G. CLAYTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1930

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1930, to June 6, 1930, that I last saw h/m alive on June 6, 1930, and that death occurred, on the date stated above, at 9 P.M. m.

The CAUSE OF DEATH* was as follows:

Secondary Hemorrhage from Rectum.

(duration) yrs. 1 mos 8 hrs da.

CONTRIBUTORY (Secondary) Imperforate anus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-6-30

Imperforate anus operated

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Emil H. Novak Jr. M. D.

6/7, 1930 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Some Assistant Health

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 57975

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 57975

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (NO. 1314 E Lafayette Ave ST., 9-18 WARD)

2-FULL NAME John D Pfeiffer.

(a) RESIDENCE NO. 1314 E Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Christina Pfeiffer

6 DATE OF BIRTH (month, day, and year) 12-10-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Pfeiffer

(Address) 1314 E Lafayette W

Filed JAN 2 1930 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1930, to Jan 12 1930, that I last saw him alive on Jan 11 1930, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 1 mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W Vandiver M. D.

1/12/1930 (Address) 1714 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

UNDERTAKER George J Pfeiffer Jr 1735

DATE OF BURIAL 1/15 1930

ADDRESS Harford Ave

ATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 57976

E 57976

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 S. Ann ST. 7-4 WARD)

2—FULL NAME CATHERINE BEHRINGER

(a) RESIDENCE NO. 204 S. Ann ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Behringer

6 DATE OF BIRTH (month, day, and year) July 19, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Andrew Seibert

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Baum

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Philip Behringer (Husband)
(Address) 204 S. Ann St.

15 Filed 12 1930 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1 - 1930, to June 10 1930, that I last saw h- alive on June 10 1930 and that death occurred, on the date stated above, at 2.00 p. m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis - Senile

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Contrac fracture

(duration) yrs. 1/2 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) [signature], M. D.

, 19 (Address) 125 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Oak Lawn Cemetery

DATE OF BURIAL
June 13, 1930

20 UNDERTAKER
Henry Sander & Sons Inc

ADDRESS
Baltimore St. & Broadway.

Important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 57972

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57977

CERTIFICATE OF DEATH

74-081

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2010 E. Biddle ST. 8-13 WARD)

2-FULL NAME Frederick T. Hasel

(a) RESIDENCE NO 2010 E. Biddle ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Hasel

6 DATE OF BIRTH (month, day, and year) Dec 9/1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	6	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Jos. T. Enge

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Hasel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Hershman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Hasel
(Address) 2010 E. Biddle St

15 Filed 2 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D. Coroner

6/12/30 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetary

DATE OF BURIAL 6/14/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

FRONT very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57978

CERTIFICATE OF DEATH.

E 57977

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1021 E Preston St (St.) (Ward) 10-1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Andrew George Law

(a) RESIDENCE. No. 1021 E. Preston St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced, ~~WIFE of~~ HUSBAND of Catherine Law

6 DATE OF BIRTH (month, day, and year) Oct 17-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70 yrs	8 7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cobbler -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Geo Law

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Louisa Unger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Catherine Law

(Address) 1021 E Preston St

15 Filed 1 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-11- 1930.

17 I HEREBY CERTIFY, That I attended deceased from 6-5-, 1930, to 6-11-, 1930, that I last saw him alive on 6-11-, 1930, and that death occurred, on the date stated above, at 11.20 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Pulmonary oedema (duration) yrs. 7 mos. ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Abner Bowden, M. D.

6/11, 1930 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Oxford, Pa

DATE OF BURIAL 6/13 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-30—M. & T.—250 Rms.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57979 ✓ 90 E 57979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 N. Patt. Park Ave ST. 6-19 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Tappan

(a) RESIDENCE NO. 103 N. Patt. Pk Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. ... mos. ... da. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Tappan

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Tappan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jacob —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1439 E Balt St

Filed N 1-3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12th 30

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1928, to June 7, 1930, that I last saw him alive on June 7, 1930, and that death occurred, on the date stated above, at 5 45 P. m.

The CAUSE OF DEATH* was as follows:

Ch Myocarditis

(duration) 2 yrs. ... mos ... da.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. E. Hamilton, M. D.

6/13, 1930 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holum Int. Council	6-13- 1930
UNDERTAKER	ADDRESS
Jack Lewis,	1439 E Balt St

Penalty for making any false statement in this certificate is a fine of not more than $100 or imprisonment for not more than 60 days, or both. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—800 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57980

CERTIFICATE OF DEATH

74-001

E 57980

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1008 S. Chapel St ST. 23-31 WARD)

2—FULL NAME George E. Simms

(a) RESIDENCE NO. 1008 S. Chapel St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): ~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellen Simms

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 54 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Preacher

(b) General nature of industry, business, or establishment in which employed (or employer): old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co. Md

PARENTS

10 NAME OF FATHER: Geo. Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Ollie Shipley

(Address): 1008 Chapel St

15 Filed JUN 13 1930 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 1930

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1930, to June 10, 1930, that I last saw him alive on June 10, 1930, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) ... yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. 2 mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Observation & Symptoms

(Signed) Charles R. Howard, M. D.

June 11 1930 (Address) 712 S. Chapel St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MT Albion	June 13 1930
20 UNDERTAKER	ADDRESS
J. L. S. Brown & Son	108 W. Monty

Spec.—1-30—M. & T.—250 Blks.

E 57981

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57981

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Balto. Gen. Hosp. REGISTERED NO. 22321

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ..... ST., ... WARD

2-FULL NAME Lottie Hannah Warren

(a) RESIDENCE NO. 819 Hanover ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John Warren

6 DATE OF BIRTH (month, day, and year) Sept 12 - 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Joseph Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alice Branch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John Warner

(Address) 819 Hanover St

Filed JUN 13 1930 HARRISON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-10-30

17 I HEREBY CERTIFY, That I attended deceased from 5-30-30, 19..., to 6-10-30, 19..., that I last saw h.. alive on 6-10-30, 19..., and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic P.L.D.

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of 6-3-30

Was there an autopsy? No Wound Labs. Cancer

What test confirmed diagnosis? Operation

(Signed) Frances W. Gillen, M. D.

, 19 (Address) So. Balto. Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct — DATE OF BURIAL June 13 1930

20 UNDERTAKER J. L. Brown & Son — ADDRESS 108 W. Monument

IMPORTANT: See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 57982 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 57982

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.) 17-24 31 REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oliver Felton

(a) RESIDENCE No. 527 W. Biddle st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Felton

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Chair factory

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) C. HAMPSON JONES, M. D.

Filed JUN 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to June 9, 1930, that I last saw him alive on June 9, 1930, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

6-11 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL June 13 1930

20 UNDERTAKER [illegible] ADDRESS 1878 W. Biddle

1-30—M. & T.—100 B—50L

E 57983

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57983

CERTIFICATE OF DEATH

188-103

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hos ST. 19-28 (Ward))

2-FULL NAME W T. Tyler

(a) RESIDENCE NO 204 S. Fulton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly Tyler

6 DATE OF BIRTH (month, day, and year) June 6-1892 Baltimore

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35		5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Truck Driver
(b) General nature of industry, business, or establishment in which employed (or employer) Produce
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jno R Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Booth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Mary Kathleen

(Address) 204 S Fulton Ave

15 Filed JUN 13 1930, 192 H. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: While passing between two parked automobiles stepped into path of another car

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Franklin Sq Hospital

Did an operation precede death? yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Physical

(Signed) L. Strauss, M. D. Coroner

6-13, 1930 (Address) 2939 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 6/14/1930

20 UNDERTAKER Harry A Wetzke

ADDRESS 419 Edmondson Ave

TION is very important. See instructions on back of certificate.

...ATE of OCCUPA-

Stoec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57984

CERTIFICATE OF DEATH

14-001

E 57984

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1604 N. Caroline ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E Ahring

(a) RESIDENCE NO. 1604 N. Caroline ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 5th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6 5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Ernst H Ahring

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Elisabeth Seibel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Caroline E. Ahring

(Address) 2102 Boone St

Filed JUN 13 1930 19 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14/30

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to June 14, 1930, that I last saw her alive on June 11, 1930 and that death occurred, on the date stated above, at 10 am m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L Dandeneau, M. D.

6/14 19 30 (Address) 1716 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 14th 1930
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57985

E 57985

CERTIFICATE OF DEATH.

86-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto. Eye, Ear & Throat Hosp. (Ward) 15th

2-FULL NAME Mitchel Behrend

(a) RESIDENCE. No. 4023 Barrington St., (Ward) Road

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jany. 3, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Max M. Behrend

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Alice Ahern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Dr. M. M. Behrend

(Address) 4023 Barrington Rd.

Filed JUN 13 1930 H. RAMSAY JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1930

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,

that I last saw him alive on June 13th, 1930,

and that death occurred, on the date stated above, at 4:50 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Mastoiditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? 5/31 Date of 6/4

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Louis Disney M. D.

, 19 (Address) Cylburn Ave & Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Adrew Friendship Cem.

DATE OF BURIAL 6/15/1930

20 UNDERTAKER David Sondheim & Son

ADDRESS 1902 Eutaw Place

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57986

CERTIFICATE OF DEATH.

E 57986

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 280?-W. Lafayette ST.) (WARD) H-6?

2-FULL NAME Anthony S. Geppi

(a) RESIDENCE No. 280?-W. Lafayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6/8/30

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	—	—	4	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Vincent Geppi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Geppi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vincent Geppi (Address) 280?-W. Lafayette

15 Filed 6 13 1930 MATTHEW JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12-30

17 I HEREBY CERTIFY, That I attended deceased from June 8- 1930 to June 12 1930, that I last saw him alive on June 12 1930, and that death occurred, on the date stated above, at 11? m.

The CAUSE OF DEATH* was as follows:

Hymus Lymphatcum

(duration) ....yrs. ....mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) H. Paul, M. D.

6/13 1930 (Address) 1117 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 6/12/30.

20 UNDERTAKER Geo. J. Pugh Inc. ADDRESS 1231 Hanover

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57987 ✓ E 57987

31

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2434 Ashland Avenue ST., 7-17 WARD)

2-FULL NAME Teresa Petrella

(a) RESIDENCE No. 2434 Ashland Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 5-27-1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Giuseppe Petrilla

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Maria P. Bernardi

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Giuseppe Petrella
(Address) 2434 Ashland Ave

15 Filed JUN 13 1930 19 M. A. JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1930, to June 11, 1930,

that I last saw h[er] alive on June 11, 1930,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? - Sputum, - X-ray

(Signed) Eugene L. Pessagno, M. D.

6-13, 1930 (Address) 514 Druid Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 6/13/30.

20 UNDERTAKER George D. Rutherford

ADDRESS 1735 Hoy

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57988

CERTIFICATE OF DEATH.

122-001

E 57988

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 21-29 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Wilbert Winkle~~ WILBERT WINKEL

(a) RESIDENCE NO. 939 S. Paca St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Katherine

6 DATE OF BIRTH (month, day, and year) Nov. 24, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Roofer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Carey Roofing Co.

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Eugene

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Clara Boyd

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Records of
(Address) Balto. City Hosp.

Filed 6-13, 1930 H. A. Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-12-30

17 I HEREBY CERTIFY, That I attended deceased from 5-13-30, 19..., to 6-12-30, 19...,

that I last saw him alive on 6-12-30,

and that death occurred, on the date stated above, at 6:45 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

over

Moyethon (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Anaemia, Secondary UNKNOWN (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam

(Signed) Paul Padget. M. D.

6-13, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk

DATE OF BURIAL 6-16 1930

20 UNDERTAKER Bernard C. Haile

ADDRESS 1000 S Paca St

IMPORTANT: See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 57989 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 57989

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (No. 14-27 ST. WARD)

2-FULL NAME Mildred Savage

(a) RESIDENCE No. 222 N. Mount st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Eugene Toney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Gertrude Marsel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed JUN 13 1930 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1930, to June 12, 1930, that I last saw her alive on June 12, 1930, and that death occurred, on the date stated above, at 7.08 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

6-12 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	6-15 1930
UNDERTAKER Gross F. A. Schroe	ADDRESS 1763 10 mile Hobson

Per

Cor.—10-10-29—A Co.—100 Bks.

E 57990

HEALTH DEPARTMENT—CITY [redacted]

CERTIFICATE OF DEATH [redacted]

40 v

REGISTERED NO. E 57990

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hosp. St., Ward 5-8)

2-FULL NAME Wayman Taylor

(a) RESIDENCE NO. 607 Aisquith St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1910

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	20	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O&O
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) U. S.

PARENTS

10 NAME OF FATHER Harris Taylor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) U. S.

12 MAIDEN NAME OF MOTHER Annie Stafford

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) U. S.

14 Informant Estella Thompson
(Address) 607 Augusta St.

15 Filed ..., 19... C. Hampton JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10/30 1932

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis (probably Gonococcic)

Abcess in Prostate Gland

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) [redacted], M. D.

6/11/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenlawn	6-13 1930
UNDERTAKER	ADDRESS
Daniel Easton	916 E. Fayette

JUN 13 1930

Spec.—1-30—M. & T.—250 Bks.

E 57991

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57991

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital 8-17 (Ward)
Casualty & Clinic

2-FULL NAME 1417 N. Washington Street

(a) ~~Residence~~ Name Mrs Antonia Sladek St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	W. Lowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Anton Sladek

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) O'W

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Frank Koralik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Anna Sladek

(Address) 1417 N Washington St

Filed JUN 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-12-30

17 I HEREBY CERTIFY, That I attended deceased from 6-2, 1930, to 6-12, 1930

that I last saw her alive on 6-12, 1930

and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus
Atheroscleosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. B. Kundry, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: June 16 1930

UNDERTAKER: Frank Cronin — ADDRESS: 1906 Eutaw

IMPORTANT. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 7064
~~E~~ 57992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 57992

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 23-31 WARD)

2-FULL NAME Emily Kurtz

(a) RESIDENCE NO. 902 S Hanover ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
f	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Wm. Alfred P. Kurtz

6 DATE OF BIRTH (month, day, and year) June 1st-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. ife

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Jas S. Harding

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Eliza Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

Filed JUN 3 1930 Reg. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11-1930

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1930, to June 11, 1930, that I last saw her alive on June 11, 1930, and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatic Endocarditis

14 (duration) — yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) James Bordley — M. D.

6-11, 1930 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery, DATE OF BURIAL June 14, 1930

UNDERTAKER Fred A. Schumacher ADDRESS 703 Hanover

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 57993 E 57993 E 57993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 N. Ostend ST. 21-29 WARD)

2-FULL NAME John A. Adams

(a) RESIDENCE NO. 1415 N. Ostend ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary T. Adams

6 DATE OF BIRTH (month, day, and year) Mar 22, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Westport Paving

(c) Name of employer Brick Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Lilly B. Harvey (Address) 1415 N. Ostend St.

15 Filed JUN 13 1930 C. HAMILTON JONES, By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929 to June 12, 1930 that I last saw h.. alive on 6/12/30, 19 and that death occurred, on the date stated above, at 6.50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nefritis

8 (duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) General Edema

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Dorn M. D.

, 19 (Address) 727 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL June 14, 1930.

20 UNDERTAKER Mr. Mrs. John W. Teufel & Son — ADDRESS 801 W. Fayette

IMPORTANT. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E57994

HEALTH DEPARTMENT—CITY OF BALTIMORE

E57994

E 57994

CERTIFICATE OF DEATH

118-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1361 Whitehall St., 15-21 Ward)

2-FULL NAME Phebie J Deveaux

(a) RESIDENCE NO. 1361 Whitehall St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb 22-1917

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	13	3	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer L C

9 BIRTHPLACE (city or town) L. C.
(State or country)

PARENTS

10 NAME OF FATHER Richard Deveaux

11 BIRTHPLACE OF FATHER (city or town) L C.
(State or country)

12 MAIDEN NAME OF MOTHER Elsie Parker

13 BIRTHPLACE OF MOTHER (city or town) L C.
(State or country)

14 Informant Elsie Deveaux
(Address) Rochester N. Y.

15 Filed 6-13-30 16 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ...
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Autopsy
(Inquest, autopsy or inquiry)
find that said deceased came to ... death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction
(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 1361 Whitehall St
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signature) Alfred L. Brown, M. D.
June 11 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lamasse N.Y.	6-13-30
UNDERTAKER	ADDRESS
Daniel Easton	Peace

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 57995

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57995

CERTIFICATE OF DEATH

188-103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Wirtanen

(a) RESIDENCE NO Don't know ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Don't know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Don't know

6 DATE OF BIRTH (month, day, and year) Don't know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Finland

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant

(Address)

6-13-1930 192 C. HAMPSON JONES, Registrar

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck & knocked down by moving auto at Lombard & Eden

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Fract. skull

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Baltimore & Wolfe

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? C. O. Duncan

(Signed) C. O. Frame, M. D. Coroner

6, 1930 (Address) 2934 W. Eddy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUN 13 1930

20 UNDERTAKER Dept. of Municipal Health.

ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

ES 7996. HEALTH DEPARTMENT—CITY OF BALTIMORE ES 7996.

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 4 Athol Ave ST., 28-27 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Knipke

(a) RESIDENCE NO. 4 Athol Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Heubeck Knipke

6 DATE OF BIRTH (month, day, and year) Oct 1-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John C. Knipke

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Julia C. Greasley

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs Anna H. Knipke (Address) 4 Athol Ave

Filed 1-3-1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12-1930

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1930, to June 11, 1930

that I last saw h[im] alive on June 11, 1930

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris 5

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar V. Sandrock M. D.

, 19 (Address) Medical ARTS Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 14 1930
20 UNDERTAKER	ADDRESS
Wm J. Tuckner Sons	N. 7 Pa

TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 57997

E 57997

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. ×198

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 9-17 WARD)

2-FULL NAME Herbert Shipley

(a) RESIDENCE NO Fallston Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31/1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	5	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co., Md.

PARENTS

10 NAME OF FATHER Edward Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER Mattie Tetlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co., Md.

14 Informant Hornberger Gross Benson, Md.
(Address)

15 Filed JUN 13 1930 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
General Peritonotis- Stab wounds of abdomen. Homicide

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 5/30

Was there an autopsy? yes by Dr. H.J. Maldeis

What test confirmed diagnosis?

(Signed) J S Hollar, M. D. Coroner

6/13/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Chapel Cem. DATE OF BURIAL June 15 1930

20 UNDERTAKER Hornberger & Gloss ADDRESS Benson Md

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57998

CERTIFICATE OF DEATH

90 E 57998

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospt St. 2129 Ward)

2-FULL NAME Geo W. Deems (Ramsgate)

(a) RESIDENCE NO. 719 Ramsay St (Ramsgate) St., Ward

(Usual place of abode) Unknown.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Wid

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND of~~
(or) WIFE of Catherine Deems

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
47	about			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(h) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer United R. W. Co. 062

9 BIRTHPLACE (city or town) Pittsburg Pa
(State or country)

PARENTS

10 NAME OF FATHER Frederick Deems

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER M. E. Allerton

13 BIRTHPLACE OF MOTHER (city or town) Pittsburg
(State or country)

14 Informant Mrs. Anna Craigmyle
(Address) 716 Edmondson St

15 Filed ... G. HAMPSON JONES Registrar

N 13 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12-30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH*, was as follows:

1st Valv. disease Heart

Dr adm (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. Peters, M. D.

June 17 19 30 (Address) 16 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	DATE OF BURIAL
Western Cem	June 14 1930
20 UNDERTAKER Geo W Little	ADDRESS 2700 Edmondson Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 57999

CERTIFICATE OF DEATH

E 57999

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 536 W Lanvale St. 17-24 Ward)

2-FULL NAME Mary Thomas

(a) RESIDENCE NO. 536 W Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 1908

7 AGE: Years 22 | Months 1 | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: maid
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Atlantic City
(State or country) N J

PARENTS

10 NAME OF FATHER: Jas Thomas

11 BIRTHPLACE OF FATHER (City or town): St Mary Co.
(State or country) Md

12 MAIDEN NAME OF MOTHER: Sarah Curry

13 BIRTHPLACE OF MOTHER (City or town): Abbeville
(State or country) S C

14 Informant: Minnie Wallace
(Address) 536 W Lanvale St

15 Filed 1930, 19 ARH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriology

(Signed) A. Gilchrist M. D.

May 30 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: JUN 13 1930 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THE MORGUE

Spec.—1-30—M. & T.—250 Bks.

E 58000 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58000

CERTIFICATE OF DEATH.

REGISTERED NO. 137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1305 Linden Ave ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Tinges.

(a) RESIDENCE NO. 1305 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: Mulo

5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word): Single

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Jan 1st 1848

7 AGE: Years 82 | Months 5 | Days 12 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: George W Tinges

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Sarah Tings.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass.

14 Informant: Emma W Tinges

(Address): 1305 Linden Ave

Filed JUN 13 1930, 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1930

17 I HEREBY CERTIFY, That I attended deceased from May —, 1921, to June 13, 1930

that I last saw h[illegible] alive on June 12, 1930

and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Ovarian Cyst —

over 9 yrs. — mos — ds.

(duration)

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) est. 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Autopsy —

(Signed) Chas W. Larmour M. D.

6-13, 1930 (Address) 1327 North Ave —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: June 14 1930

UNDERTAKER: Henry Wenkes Sons Co

ADDRESS: Orchard Ave-Govans

Spec.—1-30—M. & T.—250 Blks

E 5800

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5800

CERTIFICATE OF DEATH.

74 E 01

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 11-15 ST (WARD)

2-FULL NAME James Horisberg

(a) RESIDENCE NO. 7 E. Preston St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of A. Viola

6 DATE OF BIRTH (month, day, and year) February 14, 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
72	74	0	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bank Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Central Savings Bank

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Rudolph Horisberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Margaret Harbeke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Hospital Records (Address)

15 Filed 6 13 1930 C. [redacted]SON JONES, M. D. [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH 1 P.M.

16 DATE OF DEATH (month, day, and year) June 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from 6-12, 1930, to 6-13, 1930, that I last saw him alive on 6-13, 1930, and that death occurred, on the date stated above, at 12 45 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyko, M. D.

6/13 1930 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 6/16/1930

20 UNDERTAKER Wm Cook — ADDRESS 1219 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

TYRRELL

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58002

CERTIFICATE OF DEATH

49 E 58002

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 808 N. Appleton St. Ward 16-22

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E.C. Tyrrell

(a) RESIDENCE NO. 808 N. Appleton St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Raymond J.

6 DATE OF BIRTH (month, day, and year) June 9 1863

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	67	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer self

9 BIRTHPLACE (city or town) Annapolis, Md

(State or country)

PARENTS

10 NAME OF FATHER Robert V. Clayton

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Sinnett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Raymond J. Tyrrell.

(Address) 808 N. Appleton St

15 Filed JUN 13 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1930, to June 13, 1930

that I last saw her alive on June 13, 1930,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Contractor

(Signed) A. C. Smith, M. D.

June 13, 1930 (Address) 4309 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis, Md. Date of Burial 6/16/1930

20 UNDERTAKER Wm Cook 1917 ADDRESS St Paul St

C. ELLISON JONES, M. D. Registrar

R.—WRITE PLAINLY, WITH LEAD PENCIL. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 58003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58003

1—PLACE OF DEATH

REGISTERED NO. 161-002

CITY OF BALTIMORE: (No. 710 Gold ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Dixon

(a) RESIDENCE NO. 710 Gold ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): June 10 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): 710 Gold St

PARENTS

10 NAME OF FATHER: Clarence Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mrs Elizabeth Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mrs E Dixon
(Address): 710 Gold St.

15 Filed , 19 Registrar

JUN 13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1930

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1930, to June 11, 1930, that I last saw h[illegible] alive on June 11, 1930 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis Left Acute Mucous Pelvis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Ulcers (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H Wright, M. D.

6/12, 1930 (Address) 1209 Preston ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	June 13 1930
20 UNDERTAKER: Thomas E Kelson	ADDRESS: 1302 Pennsylvania Ave

OF DEATH in plain terms, so that it may be of value in protecting property rights. Every statement important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58004

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

+ 1-001

E 58004

REGISTERED NO.

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 25-77 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Dawson Jr.

(a) RESIDENCE NO. Greenwood Rd (St.) Towson (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 15-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	12	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Chas. E. Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Gertrude Lundeen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Chas. Edw. Dawson

(Address) Lutherville Md. Md.

15 JUN 14 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13- 1930

17

I HEREBY CERTIFY, That I attended deceased from 5-24 1930 to 6-13 1930

that I last saw him alive on 6-13 1930

and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

. 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: 6/16/1930

20 UNDERTAKER: Henry A Witzke — ADDRESS: 401 Edmondson Ave

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

N 14 1930

Spec.—1-30—M. & T.—250 Bks.

E 58005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 E 58005

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N Castle ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa L Werner

(a) RESIDENCE NO. 508 N Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Werner

6 DATE OF BIRTH (month, day, and year) Mar 14-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Louise Werner

(Address) 508 N Castle St

15 Filed JUN 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11-1930

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1930 to June 11, 1930, that I last saw h. alive on June 10, 1930 and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Lovell, M.D.

6/11, 1930 (Address) 413 N Washington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dale Cem

DATE OF BURIAL June 14 1930

ADDRESS

20 UNDERTAKER John Allen

CAUSE OF DEATH: In plain terms, so that it may be understood. See instructions on back of certificates.

JUN 14 1930

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58006

E 58006

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Md Gen Hospital (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Elizabeth Ann Dean

(a) RESIDENCE NO. 801 N Eutaw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31-1894

7 AGE: Years 36 Months Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Dr. John W. Dean

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Annie W. Killman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hospt Records

15 Filed JUN 14 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1930

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930 to June 13, 1930.

That I last saw her alive on June 13, 1930,

and that death occurred, on the date stated above, at 2-45 P m.

The CAUSE OF DEATH* was as follows:

Ca of Sigmoid and Intestinal Obstruction

Time between ~~onset and death~~ (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction (duration) About 6 mos.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of June 12-'30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Operative

(Signed) [illegible] M. D.

(Address) [illegible]

*Sign the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge June 16 1930

DATE OF BURIAL

UNDERTAKER: John C. Middendorf Sons 190 Eutaw

ADDRESS Pl

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 58007

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 ✓ E 58007

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST. 8-16 WARD)

2-FULL NAME Walter Darr

(a) RESIDENCE NO 1508 N. Madeira ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11/26

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	11	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Herman O. Darr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elsie R. Vollmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elsie R. Darr
(Address) 1508 N. Madeira St

15 JUN 14 1930 19 C. RAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- Burns over 2/3 body
Clothing caught fire while playing with matches- accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. H. Culler, M. D. Coroner

6/13/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Michaels Luth. Cmetery	June 15, 30
20 UNDERTAKER	ADDRESS
Fred'k Lissahan	1061 Fullerton

MEDICAL BOARD OF CHARITY, Baltimore. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58008

CERTIFICATE OF DEATH

90 ✓

E 58008

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2822 Hollins Ferry Road St., 25-73 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Mary Leckner

(a) RESIDENCE NO. 2822 Hollins Ferry Rd St. ✓ Ward ✓

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~Lifetime~~ yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 19 - 1911

7 AGE	Years	Months	Days 23
	19	0	24

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Packer - fdc

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer Dockman Candy Co.

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Louis Leckner

11 BIRTHPLACE OF FATHER (City or town) Baltimore Md.

(State or country)

12 MAIDEN NAME OF MOTHER Nellie Knabe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant Arthur Leckner

(Address) 2822 Hollins Ferry Rd.

JUN 14 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1930

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 12, 1930; that I last saw h. ✓ alive on June 12, 1930, and that death occurred, on the date stated above, at 4.45 p (Standard)

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) ✓ yrs. 2 mos. ✓ ds.

CONTRIBUTORY (Secondary) Acute Streptococcus

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No. Clinical methods

What test confirmed diagnosis?

(Signed) George C. Shannon, M. D.

6/12, 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross (Ilchester Rd)

Date of Burial 19

20 UNDERTAKER William Cook

ADDRESS 1217 E. Baltimore St

8—WRITE PLAINLY, WITH LEAD PENCIL. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-30—A Co.—100 Bks.

58009

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 58009

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1319 St Fayette St 19-1a Ward)

2-FULL NAME Martinas Paska

(a) RESIDENCE NO. 1319 St Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	St Lite	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Karalus

6 DATE OF BIRTH (month, day and year) 1865

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work no
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lithuania
(State or country)

PARENTS

10 NAME OF FATHER B. Paska

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Anne Jugapetis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Elizabeth Paska
(Address) 1319 St Fayette

15 Filed ..... 19 ..... HAMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/13 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Moore M. D.

6/14. 1930 (Address) 3601 3 Fr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 16. 1930
20 UNDERTAKER	ADDRESS
John Grebliauckas J G	423 S Paca St

N. B.—[illegible] tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should take CARE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNI 4 1930

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58010 E 58010

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. En route to University Hospital Ward) 6-12-30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Stula (Jr)

(a) RESIDENCE NO. 816 W. Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	29			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

080

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Peter Stula

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Sophia Abisunas
(Address) 816 W. Lombard St

15 Filed JUN 14 1930 HAMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers M. D.

6/14 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 16 1930
20 UNDERTAKER	ADDRESS
John Grebliauckas J. G.	423 S Paca St

N. B.—WRITE PLAINLY, with ink. Name of deceased should be stated EXACTLY. PHYSICIANS should be careful in filling out this certificate. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 58011

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58011

CERTIFICATE OF DEATH

172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital St. 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Stricker

(a) **RESIDENCE** No 1617 E. Chase St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Stricker

6 DATE OF BIRTH (month, day, and year) May 15/1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	0	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Frank J. Stricker
(Address) 717 E. 37th St

15 Filed ....., 192.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- Fractured skull & rt ankle
(Jumped out 2nd story window.
Probably Suicide)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. McCann, M. D. Coroner

6/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cem	June 16 1930
20 UNDERTAKER Chunowith Bond	ADDRESS 3615 Elmsted

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 14 1930

Spec—12-23-21—E.B.R.S.—400 Bks.

E 58012 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58012

CERTIFICATE OF DEATH.

5/

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3022 Darby St. St. 13-51 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William H. Ott

(a) Residence No. 3022 Darby St. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. male

4-COLOR OR RACE. White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 16 1912

7-AGE. 17 yrs. 11 mos. 26 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Mill Hand

(b) General nature of industry, business, or establishment in which employed (or employer). 046

(c) Name of employer. .....

9-BIRTHPLACE (city or town) (State or Country). md

PARENTS.

10-NAME OF FATHER. George H. Ott.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). md

12-MAIDEN NAME OF MOTHER. Rosa L. Simonds

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). md

14- (Informant) George H. Ott

(Address) 3022 Darby St

15- Filed JUN 14 1930 Registrar. Rlh

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June. 12-30

17- I HEREBY CERTIFY, That I attended deceased from May 28 1930 to June 12 1930

that I last saw h.. alive on June 12 1930

and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Articular Rheumatism 20 dys.

Acute Parenchymatous Nephritis (Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (Duration) yrs. mos. 12 h. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. R. Miller M. D

6/13/30 (Address) 2757 La Fontaine

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Park — DATE OF BURIAL. June 16, 1930

20-UNDERTAKER. Schnorrenberg Son — ADDRESS 3615 Eastern Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 58013

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58013

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. _____ ST. 13-57 WARD)

2-FULL NAME Katie Maisel

(a) RESIDENCE NO. 2910 Bernard ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? 49 yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John

6 DATE OF BIRTH (month, day, and year) June 15, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	72	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____ (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Shanbert

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Weber

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) Germany

14 Informant Records of (Address) Balto. City Hospitals

15 Filed JUN 14 1930, 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-12-30

17 I HEREBY CERTIFY, That I attended deceased from 6-3-30, 19____, to 6-12-30, 19____,

that I last saw her alive on 6-12-30, 19____,

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Movethon 4 (duration) 4 yrs. _____ mos _____ ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic + acute (duration) unknown yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Exam. lab.

(Signed) Paul Padget, M. D.

6-13, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	June 16 1930
20 UNDERTAKER Thenowetson	ADDRESS 3615 Clifton Ave

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

N 14 1930

Spec.–7-17-26—A Co.—200 Bks.

E 58014

HEALTH DEPARTMENT—CITY OF BALTIMORE

60 V 001

CERTIFICATE OF DEATH

E 58014

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4700 Homer Ave St., 27-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Blanch Graham

(a) RESIDENCE NO. 4700 Homer Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Samuel E Graham

6 DATE OF BIRTH (month, day, and year) Aug 23 – 1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) own home

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Daniel B Lightner

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Eyler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Carroll Graham

(Address) Hampstead Md

15 Filed JUN 14 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/12 1930

17 I HEREBY CERTIFY, That I attended deceased from 6/7, 1930, to 6/12, 1930, that I last saw h alive on 6/12, 1930, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (terminal)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Hamilton Jones, M. D.

6/14, 1930 (Address) (2270) Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Bridge Md — Date of Burial June 16 1930

20 UNDERTAKER Edw C Tipton — ADDRESS Hampstead Md

N. B.—WRITE plainly, with pen and ink. All questions should be answered. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 58015

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

18 VE 58015

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Key Highway & Hughes St. 22-30 St., Ward)

2-FULL NAME Samuel Allen. C.

(a) RESIDENCE NO. 609 S. Sharp St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ---mos.---dys. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	10	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Allen. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Estelle Floyd. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant George Floyd. (C) uncle.
(Address) 609 S. Sharp St.

15 Filed JUN 14 1930 19... HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

Jumped overboard into deep water and could not swim.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [signature], M. D.

6/18 1930. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	6/16/30
20 UNDERTAKER R. L. Parham	ADDRESS Annapolis Md.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58016

CERTIFICATE OF DEATH.

E 58016

Registered No. 89

1-PLACE OF DEATH

City of BALTIMORE: (No. 4909 Edmondson Ave ... Ward 48-71)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel J. Loden

(a) Residence No. 4909 Edmondson Ave. ... Ward ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Delia Loden

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 60 yrs. ... mos. ... ds. If LESS than 1 day ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Manager 086

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9-BIRTHPLACE (city or town). Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER. Dennis Loden

11-BIRTHPLACE OF FATHER (city or town) ... (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Lanahan

13-BIRTHPLACE OF MOTHER (city or town) ... (State or Country), Ireland

14- (Informant) John J. Loden

(Address) Edmondson Ave. Catonsville Md

15- Filed JUN 14 1930 C. ... Registrar. JONES, H.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/13/30

17- I HEREBY CERTIFY, That I attended deceased from June 9 1930 to June 12 1930

that I last saw h... alive on June 12 1930

and that death occurred, on the date stated above, at 12 N.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

angina Pectoris

(Duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) acute Pancreatitis

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) John J. Nugent M. D

6/16, 1930 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL. June 16, 1930

20-UNDERTAKER, J. Vernon Hechmer — ADDRESS 153 Hollins

In plain terms, so that it may be properly classified. Exact statement of occupation required. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58017

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4980 Edgemere Ct.; or Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minerva Lenora Wright

(Residence in Baltimore: No. 4980 Edgemere Ct. St.; yrs., 7 mos. ds.) Woodlawn, Md.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Nov. 7, 1861 (Month) (Day) (Year)

7-AGE, 68 yrs. 7 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Jonath D. Warfield.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Jane Gore.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jonath Wright

(Address) 7201 Garrison Blvd.

15- Filed ..... 191.... Reg. C. HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 13, 1930. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1930, to June 13 1930, that I saw h[illegible] alive on June 13 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Arteriosclerosis - 10 years)

(Duration) ....yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary) Hypertension - memory.

(Duration) ....yrs. ....mos. 3 ds.

(Signed) Thomas F. Warner M. D.

June 13, 1930 (Address) 2604 Garrison Blvd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Freedom Cemetery DATE OF BURIAL: June 15, 1930.

20-UNDERTAKER C. M. Watts ADDRESS Winfield Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

Mary Anello

E 58018 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58018

60-08

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 41 Jas. Hoff ST., 12-50 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Anello

(a) RESIDENCE No. 346 Whitridge Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Thomas Anello

6 DATE OF BIRTH (month, day, and year) 12/24 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Jos Paistigrasomo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Lona Paestrigrasomo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Thomas Anello
(Address) 346 Whitridge Ave

15 Filed 6-14-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/14/30

17 I HEREBY CERTIFY, That I attended deceased from 3/10/30, 19..., to 6/14/30, 19..., that I last saw her alive on 6/13/30, 19..., and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

toxic adenoma thyroid

(duration) 2 yrs. mos da.

CONTRIBUTORY (Secondary) cardiac decompensation

(duration) yrs. mos. 10 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/13/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Thaudrus, M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 6/17/30

20 UNDERTAKER Geo Ruddy Inc

ADDRESS 1135 Hope

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 58019

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 68 | 31

E 58019

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. West Balt. Gen'l Hosp. ST. WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Howard Quarles

(a) RESIDENCE NO. Whitehall, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Quarles.

6 DATE OF BIRTH (month, day, and year) July 26 1906.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	10	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer Gen'l
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS
10 NAME OF FATHER Howard Quarles
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.
12 MAIDEN NAME OF MOTHER Margaret Willey
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Howard Quarles.
(Address) Balto Md

Filed JUN 14 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13-1930

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to June 13, 1930, that I last saw h alive on June 13, 1930, and that death occurred, on the date stated above, at 11:50 A.M.

The CAUSE OF DEATH* was as follows: Staphlococcus Septicemia

(duration) yrs. mos 4-2wks ds. ?

CONTRIBUTORY (Secondary) Unknown — Probable Cerebral Abscess (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home
Did an operation precede death? Yes Date of 6-11-30
Was there an autopsy? No
What test confirmed diagnosis? Clinical.

(Signed) S. A. Allen M. D.
19 (Address) West Balto Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill York Pa
20 UNDERTAKER Edmonds Funeral Home

DATE OF BURIAL June 16 1930
ADDRESS 3610 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 58020

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58020

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hosp (St.) (Ward)

2-FULL NAME Clifford E Blaylock

(a) RESIDENCE NO. 1 Reisterstown Rd St., Md Ward Reisterstown

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lydia Blaylock

6 DATE OF BIRTH (month, day, and year) Mar 17-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	2	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Auto Tire
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer suppliers

9 BIRTHPLACE (city or town) Ohio
(State or country)

PARENTS

10 NAME OF FATHER Edw Blaylock

11 BIRTHPLACE OF FATHER (City or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Ruth Morrow

13 BIRTHPLACE OF MOTHER (City or town) Canada
(State or country)

14 Informant Lydia Blaylock
(Address) Reisterstown Md

15 Filed JUN 14 1930 H. HAMBLETON JONES, M. D. Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. ATTENTION is very important. See instructions on back of certificates.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident which he was driving overturned throwing him to Road

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Fract. Skull

(duration) yrs. mos. da.

18 Where was disease contracted, if not at place of death? Reisterstown Rd at Pleasant Hill

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. J. Frame, M. D.

6 1930 (Address) 2939 W. Eldeg Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 17, 30
20 UNDERTAKER	ADDRESS
J. F. Ellis	Reisterstown Md

Spec.—1-30—M. & T.—250 Blks

E 58021 HEALTH DEPARTMENT—CITY OF BALTIMORE 71-001 E 58021

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 N. Eden St., 10-13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Theresa Ruppert

(a) RESIDENCE No. 929 N. Eden ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis C. Ruppert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Anna C. Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mr. Louis C. Ruppert
(Address) 929 N Eden St

Filed JUN 14 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1930

17 I HEREBY CERTIFY, That I attended deceased from June 13th 1930 to June 15th 1930, that I last saw h[illegible] alive on June 14th 1930, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. H. Singer, M. D.

(Address) Hyde Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL June 16 1930

20 UNDERTAKER Henry Koch Sons, Inc. ADDRESS 1301 E Eager St

CAUSE OF DEATH. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58022

CERTIFICATE OF DEATH.

E. 58022

100

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) S. 27-41 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hallie F.o Hartman

(a) RESIDENCE NO. 4101 Harris Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13 1930

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Edward R. Hartman

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Marion Saunders

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Mrs Edward R Hartman

(Address) 4101 Harris Ave

C. RAMSON JONES M.D. Registrar

JUN 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/13/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1930, to June 13, 1930,

that I last saw him alive on June 13, 1930,

and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel J. Taylor M. D.

6/14, 1930 (Address) Johns Hop.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 16 1930
20 UNDERTAKER Henry Hoeck Funl Dir.	ADDRESS 1316 E Eager St

Note is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 58023

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58023

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1411 Washington Blvd (ST.) 21-28 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Shawker

(a) RESIDENCE NO. 1411 Washington Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth M. Shawker

6 DATE OF BIRTH (month, day, and year) Nov. 3-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carter, Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Daniel Shawker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth M. Shawker

(Address) 1411 Wash. Blvd

Filed ....., 19.... HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1928 to June 14, 1930, that I last saw h... alive on June 14, 1930 and that death occurred, on the date stated above, at 9:45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (Heart Disease)

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Skeladenwshy M. D.

6/14, 1930 (Address) 642 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 6/17 1930

20 UNDERTAKER W. M. Cook

ADDRESS 1217 E. Fort Ave

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 58024

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58024

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. University Hospital 42-54 WARD)

2-FULL NAME Charles Sherman Ford

(a) RESIDENCE NO. 2737 Bernard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 5th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65		10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thos. M. Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah A Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mina B. Shuck

(Address) 2737 Bernard St.

15 Filed 1930 G. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1930, to June 14, 1930, that I last saw h[illegible] alive on June 14, 1930, and that death occurred, on the date stated above, at 4 00 P m.

The CAUSE OF DEATH* was as follows:

Hypertensive Heart Disease with nephritis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hem

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory

(Signed) George H. Yeager, M. D.

4/14, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon National Cemetery	6/17/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 E Pratt St

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58025 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58025

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore General (Street) Hospital (Ward)

REGISTERED NO. 27-41

(If death occurred in hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mabel J. Brown

(a) RESIDENCE NO. 4928 Belair Rd (St.), (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of William F. Brown

6 DATE OF BIRTH (month, day, and year) Oct. 24, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~38~~	37	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Mr Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Mr. William F. Brown

(Address) 4928 Belair Road

15 Filed JUN 15 1930, 19 HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-14-30

17 I HEREBY CERTIFY, That I attended deceased from 6-12, 1930 to 6-14, 1930

that I last saw her alive on 6-14, 1930

and that death occurred, on the date stated above, at 10.30 A.m.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage

Shock

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of cervix

(duration) 10 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6-14-30

Was there an autopsy? no

What test confirmed diagnosis? Physical Findings

(Signed) Joseph B. Kaufkaitis M. D.

6/14 1930 (Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL June 17, 30

20 UNDERTAKER Cook

ADDRESS 1003 West Baltimore St.

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58026

E 58026

CERTIFICATE OF DEATH

11-002

REGISTERED NO. 12-51

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 Maryland Ave ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Levis Mitchell

(a) RESIDENCE NO. 2112 Maryland Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Whitely Mitchell

6 DATE OF BIRTH (month, day, and year) May 10, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	84	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cecil County
(State or country) Maryland

PARENTS

10 NAME OF FATHER Norris Levis

11 BIRTHPLACE OF FATHER (city or town) Delaware County
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Eliza Kirk

13 BIRTHPLACE OF MOTHER (city or town) Cecil County
(State or country) Maryland

14 Informant Dr. Robert L. Mitchell

(Address) 2112 Maryland Ave.

15 Filed JUN 15 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1920. to June 13, 1930.

that I last saw h er alive on June 12, 1930.

and that death occurred, on the date stated above, at 3.50 A. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. M. Smith, M. D.

6/13. 1930 (Address) 2435 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton, Md.

DATE OF BURIAL June 16, 1930

20 UNDERTAKER Chas. H. Cook

ADDRESS 1003 West Baltimore St

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58027

CERTIFICATE OF DEATH

E 58027

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Baltimore City Hospital St. 16-37 Ward

2-FULL NAME Theodor B. Dan

(a) RESIDENCE NO. 516 S. Macon St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 22-1909

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	20	10	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town)
(State or country) Ind.

PARENTS

10 NAME OF FATHER Theo. B. Dan

11 BIRTHPLACE OF ~~FATHER~~ (city or town)
(State or country) Rumania

12 MAIDEN NAME OF MOTHER Anna Wise

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Rumania

14 Informant Mrs. A. Chima
(Address) 516 S. Macon St.

15 [illegible] 1930 C. HIMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull. Accidental Death. Struck head on trolley-pole while riding (duration) street car. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Eastern Ave. Rd

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fellers, M. D.

6/14 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	June 15 1930
20 UNDERTAKER John Welch	ADDRESS 2005 Eastern

IMPORTANT—Should be carefully prepared so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 58028

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 E 58023

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2009 E. Federal ST. 8-12 WARD)

2-FULL NAME George Steen

(a) RESIDENCE NO 1200 N. Bradford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosie Steen

6 DATE OF BIRTH (month, day, and year) Feb 10/1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	4 5	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman- 66
(b) General nature of industry, business, or establishment in which employed (or employer) Household Goods
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Geo. W. Steen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington, D.C.

12 MAIDEN NAME OF MOTHER Maru Hickman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. F. Barber (Daughter)
(Address) 3625 Echodale Ave

15 Filed JUN 15 1930, 192 Registrar C. HAMPSON JONES, M. D.

CAUSE OF DEATH in plain terms, so that any person may understand it. TION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardotos Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Alcoholism?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Collins, M. D. Coroner

6/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL June 17 1930

20 UNDERTAKER Henry Lutz

ADDRESS 1203 Broadway

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58029

CERTIFICATE OF DEATH

88

E 58029

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 711 S. Bond St., 2-4 Ward)

2-FULL NAME Andrew G. Norman

(a) RESIDENCE NO. 711 S. Bond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31-1864

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	65	5	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter 015
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Norway

PARENTS

10 NAME OF FATHER Andrew Norman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Norway

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Norway

14 Informant Mrs. Bertha Munroe
(Address) 100 St. Andrews Pl. Yonkers N.Y.

15 Filed ..... 19..... C. HAMPSON JONES, Registrar
15 1930 per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs.

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Talbot, M. D.

6/15. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Grove Cem	June 16 1930
20 UNDERTAKER	ADDRESS
Louis Heeman	32 S Broad

This should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58030

CERTIFICATE OF DEATH

REGISTERED NO. 31 E 58030

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2511 Maryland Ave ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Travers Sheehan

(a) RESIDENCE NO. 2511-Maryland Ave ST., 12 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 6 mos. 6 ds. How long in U. S., if foreign birth 39 yrs. 6 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Dec-7-1890

7 AGE — Years: 39 | Months: 6 | Days: 6 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto. Maryland

PARENTS

10 NAME OF FATHER: Dennis Sheehan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Mary Loughrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Virginia

14 Informant: Mrs Mary Sheehan Brother (Address) 2511-Maryland Ave

15 Filed 6 15 1930 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/13/1930

17 I HEREBY CERTIFY, That I attended deceased from 12/22, 1929, to 6/13, 1930, that I last saw her alive on 6/13, 1930, and that death occurred, on the date stated above, at 11.50 m.

The CAUSE OF DEATH* was as follows:

Approximately 5 yrs to
Pulmonary Tuberculosis.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leo A Stockman, M. D.

, 19 (Address) 5835 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Wash Cemetery — DATE OF BURIAL: June 16 1930

20 UNDERTAKER: Stewart Mortuary Co — ADDRESS: Balto

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58031 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 58031

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 E. Fayette ST. 6-4 WARD)

2-FULL NAME Morris Lipsitz (LIPSITZ also morton Lipsey)

(a) RESIDENCE NO. 2008 E. Fayette ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Lipsitz

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Lipsitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1439 Balto St

15 Filed JUN 15 1930, 19 ... Registrar H. HARRISON JONES, M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14-1930

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1930, to June 13, 1930, that I last saw h[im] alive on June 13, 1930, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung (Primary)

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

6/14, 1930 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Lodge — DATE OF BURIAL 6-15-1930

UNDERTAKER Jack Lewis, 1439 — ADDRESS Balto St

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58032 HEALTH DEPARTMENT—CITY OF BALTIMORE 001 E 58032

CERTIFICATE OF DEATH.

REGISTERED NO. 101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 938 (Street) Brooks Lane (Ward) 13-54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME S. Hulbert Kirschenbaum

(a) RESIDENCE NO. 938 Brooks Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 9-1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mfg. 445

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob Kirschenbaum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachael —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) R.

14 Informant ... Lewis 1439 Bath St.

Filed ... 1930 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14-1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 14, 1930, that I last saw h[illegible] alive on June 14, 1930, and that death occurred, on the date stated above, at 5 20 A m.

The CAUSE OF DEATH* was as follows:

Raynaud's Disease

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Saml Wolman, M. D.

VI-14 1930 (Address) 2444 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fulton Washington Blvd. DATE OF BURIAL 6-15-1930

20 UNDERTAKER Jos. Lewis ADDRESS 1439 E Balto St.

TION IS Very Important See Instructions on Back of Certificate

Spec.—6-9-19—H. P. Co.—1000 lbks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58033

CERTIFICATE OF DEATH.

E 58033

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4309 Belleview Ave (Street) (Ward)

2-FULL NAME Caroline Link

(a) RESIDENCE. No. 4309 Belleview ave St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced (~~HUSBAND of~~) (or) WIFE of Phillip Link

6 DATE OF BIRTH (month, day, and year) Dec 6-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Ernest William Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Kessler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frieda Link
(Address) 4309 Belleview ave

15 Filed C. HAMPSON JONES, M. D. Registrar
By

JUN 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-30, 1929, to 6-13-, 1930, that I last saw her alive on 6/11/, 1930, and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism
Cerebral arteriosclerosis

(duration) yrs. 8 mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) George Elmer Bowden, M. D.

6/13. 1930 Address) 1517 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL June 16 1930

20 UNDERTAKER Martin Fahey & Sons

ADDRESS 1827 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58034

CERTIFICATE OF DEATH

90 E 58034

REGISTERED NO. 15-21

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 N. Payson ST. (AND) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude Mary Schatter

(a) RESIDENCE NO. 1604 N. Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alvin Schatter

6 DATE OF BIRTH (month, day, and year) June 16 1866

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	63	11	28	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Joseph Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Endres

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margaret M. Tauss

(Address) 1604 N. Payson St

15 MAY 19 1930 HAMILTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1 1930, to June 13 1930, that I last saw h[er] alive on June 12 1930 and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro Cerebral Hemorrhage (duration) Instant yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tilton, M. D.

6/13, 1930 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakleon Cem.

DATE OF BURIAL 6/16/30

20 UNDERTAKER Geo. D. Wood & Son

ADDRESS 1735 Hanford Ave

important. See instructions on back

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58035

CERTIFICATE OF DEATH.

E 58035

REGISTERED NO. 117-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 N. Montford Ave. ST.) (17 WARD)

2-FULL NAME Anna Porter

(a) RESIDENCE NO. 803 N. Montford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23 - 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	—	20	14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert J. Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Porter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Mary Porter 803 N. Montford Ave.

15 Filed 5-1930, 19 ... HAMPSON ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12/30

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to June 12, 1930, that I last saw h alive on June 12, 1930, and that death occurred, on the date stated above, at 6 00 P m.

The CAUSE OF DEATH* was as follows:

Intra Abdominal Hemorrhage

(duration) yrs. mos 1½ ds.

CONTRIBUTORY (Secondary) Gastro Ulcer. Anemia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptom

(Signed) Chas B Johnson, M. D.

6/14, 1930 (Address) 718 N Pat Ham

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL June 16 1930

UNDERTAKER Chas E Miller & Son — ADDRESS 2334 Jefferson St

TION is very important. See instructions on back of certificate

Spec.—1-30—M. & T.—250 Blks

E 58036

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58036

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 90

CITY OF BALTIMORE: (NO. 17-24 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bennett

(a) RESIDENCE NO. 1127 Pennsylvania Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) July 4, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
51	52	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Records of

Informant

(Address) Balto. City Hosp.

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

1 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13-30

17 I HEREBY CERTIFY, That I attended deceased from 6-10-30, 19..., to 6-13-30, 19...,

that I last saw him alive on 6-13-30, 19...,

and that death occurred, on the date stated above, at 11:15 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute.

(duration) More than yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

6-14-1930 (Address) Balto.-City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Sacred Heart

DATE OF BURIAL 6/15 1930

20 UNDERTAKER Jno F Fahey & Sons

ADDRESS 1318 Light

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

✓ E58037

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 58037

CERTIFICATE OF DEATH.

E 58037

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hosp ST. 816 WARD)

2-FULL NAME Olive Stack

(a) RESIDENCE NO. 1601 N. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	M.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Pearl J Stack

6 DATE OF BIRTH (month, day, and year) Jan 23 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 945

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Stack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Foreman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant H M Stack 70 Edmondson Ave

Address

Filed RMC Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/14/30

17 I HEREBY CERTIFY, That I attended deceased from 5-3, 1930, to 6-14, 1930,

that I last saw h in alive on 6-14, 1930,

and that death occurred, on the date stated above, at 5 00 p m.

The CAUSE OF DEATH* was as follows:

Purpura Hemorrhagica

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical & Pathological

(Signed) Lewis D. Pollock, M. D.

19 (Address) Univ Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Md

DATE OF BURIAL 6/16 1930

UNDERTAKER Wilbon Coh

ADDRESS 1217 E Fayette St

TION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

58038

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58038

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7-9 WARD)

2-FULL NAME Richard Cronin Jr.

(a) RESIDENCE NO Aberdeen, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2		10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER R. Leslie Cronin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nora Hanway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm. J. Tichner

(Address) North & Penna Aves

15 Filed ..., 192... Registrar

JUN 16 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ulcerative Laryngitis with Obstruction

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jos. H. Carey, M. D. Coroner

6/15/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Aberdeen Cemetery	June 18 1930
20 UNDERTAKER Benj. Parrott & Son / Wm. J. Tichner & Sons	ADDRESS Aberdeen Md / North & Penna

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 58039

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58039

CERTIFICATE OF DEATH

STILL BIRTH NO.

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Columbus ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Kraft

(a) RESIDENCE NO. 510 Columbus ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/10/30

7 AGE: Years — | Months 5 | Days — | If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edw Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Emma Eviller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Kraft

(Address) 510 Columbus

Filed JUN 16 1930 15 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/30

17 I HEREBY CERTIFY, That I attended deceased from 5/31/30, to 6/15/30,

that I last saw h. alive on 6/15/30,

and that death occurred, on the date stated above, at 8 9 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Davis, M. D.

, 19 (Address) 1500 Johnson Sq

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.

DATE OF BURIAL June 16th 1930

20 UNDERTAKER Geo. Leimbach

ADDRESS Lyndhurst

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

STILL B 161 001 E 58040

CERTIFICATE OF DEATH

E 58040

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Calander ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edw Kraft

(a) RESIDENCE NO. 510 Calander ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/15/30

7 AGE: Years 1 | Months | Days | If LESS than 1 day, hrs. or min.
1 Month 11 days

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hannie Ewing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jennie Kraft
(Address) 510 Calander St

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

IMPORTANT. See instructions on the back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/30

17 I HEREBY CERTIFY, That I attended deceased from 6/15/30, 19..., to 6/15/30, 19..., that I last saw h[illegible] alive on 6/15/30, 19..., and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

1 Stillborn

Premature Birth

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Hubert Dunn, M. D.

, 19 (Address) 127 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — DATE OF BURIAL: June 16th 1930

20 UNDERTAKER: Geo Leimbach — ADDRESS: 522 Lyndhurst St

JUN 16 1930

Spec.—1-30—M. & T.—250 Blks.

E 58041

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58041

CERTIFICATE OF DEATH.

REGISTERED NO. 152

1-PLACE OF DEATH The Church Home & Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount STR. 1-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary O'Toole

(a) RESIDENCE NO. The Church Home & Infirmary WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER Not Known (State or country)

14 Informant Church Home Hospital (Address)

Filed JN 16 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1930, to June 14, 1930, that I last saw her alive on June 14, 1930, and that death occurred, on the date stated above, at 9.01 A m.

The CAUSE OF DEATH* was as follows:

Focal Cellulitis

(Carbuncle of hip)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Staphylococcus Septicaemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? No Date of x

Was there an autopsy? No

What test confirmed diagnosis? Blood Cultures

(Signed) Vernon H. Norwood M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

20 UNDERTAKER Henry W. Jenkins Sons Co

DATE OF BURIAL 6/16, 1930

ADDRESS Richard McCulloh

Spec.—1-30—M. & T.—250 Blks.

2376842 E 58042 Obst

HEALTH DEPARTMENT—CITY OF BALTIMORE E 58042

CERTIFICATE OF DEATH.

146

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 18-7½ WARD)

2-FULL NAME Ella Robinson

(a) RESIDENCE NO. 919 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of George

6 DATE OF BIRTH (month, day, and year) 10-22-94

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35	36	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house wife

(b) General nature of industry, business, or establishment in which employed (or employer): — 037

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Earl Stephens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Kathryn Isabell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Relative

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 16 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-12-30

17 I HEREBY CERTIFY, That I attended deceased from 6-4-, 1930, to 6-12, 1930, that I last saw her alive on 6-12, 1930, and that death occurred, on the date stated above, at 5.55 P m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Pyelitis, pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 9, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) F F Snyder, M. D.

June 12, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: June 16, 1930

20 UNDERTAKER: Mrs Kate R. Williams — ADDRESS 322 N. Schroeder St

IT IS VERY IMPORTANT that all questions be answered fully and correctly.

Spec.—1-30—M. & T.—250 Blks.

2362 E 58046 Reng.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 58043

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 19 WARD)

2-FULL NAME Mary Ballman

(a) RESIDENCE NO. Wimbledon Rd. ST. WARD

(Usual place of abode) Middle River Md. (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

6a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of William

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER August Ackrem

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Naugat

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.

15 Filed JUN 16 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-15-30

17 I HEREBY CERTIFY, That I attended deceased from 5-5-, 1930, to 6-15-, 1930,

that I last saw her alive on 6-15-, 1930,

and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:

Common biliary duct obstruction

Common duct Stones

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Gastro jejunal - Broncho pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 6

Was there an autopsy? yes.

What test confirmed diagnosis? Operation & autopsy

(Signed) George D. Pinney, M. D.

6/15/30 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul Cemetery — DATE OF BURIAL June 18 1930

20 UNDERTAKER Louis Heemann — ADDRESS 32 S Broadway

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001

E 58044

CERTIFICATE OF DEATH

E 58044

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 734 S. Potomac St., 17 1 Ward)

2-FULL NAME John Kalb

(a) RESIDENCE NO. 734 S. Potomac St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Rosa Kalb

6 DATE OF BIRTH (month, day, and year) April 27-1852

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	78	1	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Wood Carver
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Adam Kalb

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. Philip Kalb (Son)
(Address) 734 S. Potomac St

15 Filed JUN 16 1930, 19 C. JAMESON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) June 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Poisoned by illuminating gas. Probably accidental death.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene F. Lilly, M. D.

6/16 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	June 18th 1930
20 UNDERTAKER Lilly & Zeiler Funeral	ADDRESS 403 S. Wolfe St

N 6 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 58045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-081

E 58045

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1809 McCulloh St. (Ward) 14-20

2-FULL NAME Jas F. Turner

(a) RESIDENCE NO. 1809 McCulloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Turner

6 DATE OF BIRTH (month, day and year): 1875

7 AGE: Years 55 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Fla.
(State or country)

PARENTS

10 NAME OF FATHER:

11 BIRTHPLACE OF FATHER (city or town):
(State or country)

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town):
(State or country)

14 Informant: Susie Turner
(Address) 1809 McCulloh

15 [illegible] C. [illegible], Registrar

By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Suddenly

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regarding

(Signed) [illegible], M. D.

June 13 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 6-16-1930

20 UNDERTAKER: Wm. H. Grace & Sons — ADDRESS: 1400 Mosher

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58046

CERTIFICATE OF DEATH.

129 E 58046

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 410 Pontiac Ave (St.) 25 Brooklyn (WARD)

2-FULL NAME William Henry Gardner, Sr.

(a) RESIDENCE NO. 410 Pontiac Ave St. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 9 mos. 22 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Wh

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie Belle Gardner

6 DATE OF BIRTH (month, day, and year): Aug 23-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coal Foreman Pier

(b) General nature of industry, business, or establishment in which employed (or employer): R.R. Coal Pier

(c) Name of employer: B & O R.R. Co.

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John H. Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Angeline Coulbourn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Wife (Carrie B. Gardner) (Address): 410 Pontiac Ave

15 Filed JUN 16 1930 19 C. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14 1930

17 I HEREBY CERTIFY, That I attended deceased from June 11th 1930, to June 14, 1930, that I last saw him alive on June 14, 1930, and that death occurred, on the date stated above, at 2.30 (P.M.) (D.S.T.)

The CAUSE OF DEATH* was as follows:

Nephritis, Interstitial, Chronic,
Uremia
Cerebral Hemorrhage
Undetermined (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis
Undetermined (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) R. W. Johnson, M. D.

6/14/1930 (Address) 2564 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: June 17 1930

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

CAUSE OF DEATH MUST BE FILLED IN. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 58047 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58047

E 58047 X 129

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hospital ST., ... WARD 17-44

2-FULL NAME Sarah Klingelter

(a) RESIDENCE NO. Sparks, Maryland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 13 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 26 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Luther Klingelter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cora Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant [illegible] hospital
(Address) [illegible]

N 180300 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from December 28, 1929, to June 15, 1930, that I last saw h[illegible] alive on June 15, 1930, and that death occurred, on the date stated above, at 11:35 P. m. D.S.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nicholas Sanfourche, M. D.

June 15, 1930 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Black Rock Cem. Md.

DATE OF BURIAL June 18 1930

20 UNDERTAKER J. Shaw Burns Sons

ADDRESS Towson

Spec.—1-30—M. & T.—250 Blks.

E 58048

E 58043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 58043

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Green

(a) RESIDENCE NO. 2207 Oak ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-18-29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4 17	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (O.D.)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Ernest Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ida Thornton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Records JOHNS HOPKINS HOSP. JOHNS, M. D.

15 FILED JUN 16 1930 H. HAMPSON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-15-30

17 I HEREBY CERTIFY, That I attended deceased from 6-11-, 1930, to 6-15, 1930, that I last saw him alive on 6-15, 1930, and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No Date of No

Did an operation precede death? —

Was there an autopsy? —

What test confirmed diagnosis? X Ray

(Signed) J. W. Bickford, M. D.

6/15/1930 (Address) Johns.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester C.H. Va DATE OF BURIAL June 17 30

20 UNDERTAKER Samuel I. Newsley ADDRESS 1528 Bolton

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58049 E 58049

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp. (St.) 15-54 (Ward)

2-FULL NAME Harold Lyle

(a) RESIDENCE NO. 2602 Bruce Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Lyle

6 DATE OF BIRTH (month, day, and year) April 12, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lexington

(State or country) Virginia

PARENTS

10 NAME OF FATHER Stanford Lyle

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ann Lewis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Record

(Address)

15 Filed 6-16-30 THOMPSON JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13-30

17 I HEREBY CERTIFY, That I attended deceased from 2-7, 19 30, to 6-13, 19 30, that I last saw him alive on 6-13, 19 30, and that death occurred, on the date stated above, at 5-30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic ulcerations Legs

Arteriosclerosis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Thompson, M. D.

6-16 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem'y

DATE OF BURIAL 6/16/ 1930

20 UNDERTAKER Thos. E Edelson

ADDRESS 303 Forrest St

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58050 31 E 58050

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Mercy Hosp. 3144

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Jennie Herrmann

(a) RESIDENCE NO. 2816 Rupert Ave ST., ... WARD .....
(Usual place of abode) 1410 Arlington Ave (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/12/1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35.	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 604

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John Herrmann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Jungquist

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Hosp. Records
(Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/30

17 I HEREBY CERTIFY, That I attended deceased from 6/7, 1930, to 6/15, 1930, that I last saw h[illegible] alive on 6/14, 1930, and that death occurred, on the date stated above, at 1:20 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Kidney
Tuberculous cystitis
Pulmonary tuberculosis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory tests

(Signed) Wm H McFaul Jr. M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stahl Redmen

DATE OF BURIAL June 18 1930

UNDERTAKER M. W. & Deppel Inc

ADDRESS 37 Lanvale

JUN 16 1930

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58051

CERTIFICATE OF DEATH.

E 58051

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1022 - S. 6th St., 2nd Ward

2-FULL NAME Joseph Buttka

(a) RESIDENCE NO. 1022 - S. 6th St., 2nd Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married.

5a If married, widowed, or divorced HUSBAND of (WIFE) Barbara Buttka.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bohemia.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Bohemia
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Vonzas

13 BIRTHPLACE OF MOTHER (city or town) Bohemia
(State or country)

14 Informant Barbara Zahradka
(Address) 1022 S. 6th St.

15 Filed JUN 16 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1930

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to June 14, 1930, that I last saw him alive on June 13, 1930, and that death occurred, on the date stated above, at 1 45 a. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

June 14, 1930 (Address) 481 S. Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL June 17 1930

20 UNDERTAKER Enoch Brack & Son — ADDRESS 1906 Eastern Ave

CAUSE OF DEATH in plain terms. See instructions on back of certificates.
TION is very important.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58052

CERTIFICATE OF DEATH

129 E 58052

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3228 Lyndale Ave ST. 8-40 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Webster Speddeu

(a) RESIDENCE NO. 3228 Lyndale Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	—	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co
(State or country) md

PARENTS

10 NAME OF FATHER Wm Speddeu

11 BIRTHPLACE OF FATHER (city or town) Dorchester Co
(State or country) md

12 MAIDEN NAME OF MOTHER Elizabeth Speddeu

13 BIRTHPLACE OF MOTHER (city or town) Dorchester Co
(State or country) md

14 Informant H Speddeu
(Address) 3228 Lyndale Ave

15 Filed JUN 16 1930, 19 Registrar HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1930

17 I HEREBY CERTIFY, That I attended deceased from
Apr 23, 1929, to June 14, 1930,
that I last saw h[illegible] alive on June 13, 1930
and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Chronic int, nephritis

unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia
(duration) yrs. 4 mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Path.

(Signed) Wm Stapler, M. D.

6/17, 1930 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL 6/16 1930

20 UNDERTAKER J. J. Lahey Sons — ADDRESS 131 S Light St

JUN 16 1930

1-30—M. & T.—100 B—50L

E 58053

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1880-703 ✓ E 58053

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mud Hosp- ST. 3-5 WARD)

2-FULL NAME Ignazio Puleo

(a) RESIDENCE NO 220 S. Exeter ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Puleo

6 DATE OF BIRTH (month, day, and year) Nov 4-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53	54	8	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer G & Co

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Anthony Puleo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Anthony Puleo

(Address) 220 S. Exeter St.

15 6 1930 C. HAMPSON JONES, M. D. Registrar

Per

TION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

While working on detch an auto that was they out control of Livy struck him

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Fract skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hendlestown Rd Pleasant View

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Fraun, M. D. Coroner

16 1930 (Address) 0939 m. Eldon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL June 17 1930,

20 UNDERTAKER Wendell J. Lippel

ADDRESS 320 S Eden St.

Spec.—1-30—M. & T.—250 Blks

E 58054 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58054

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 21-29 ST., WARD)

2-FULL NAME Louis J. Erich

(a) RESIDENCE NO. 1006(1026) Malldeis ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Erich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Brass

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13-30

17 I HEREBY CERTIFY, That I attended deceased from 6-26-26, 19..., to 6-13-30, 19..., that I last saw him alive on 6-13-30, 19..., and that death occurred, on the date stated above, at 3:50 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder (Urinary)

(duration) UNKNOWN yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia, secondary (duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Paul Padget, M. D.

6-14, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUN 1 1930

UNDERTAKER Dept. of Health.

ADDRESS

TION is very important. See instructions

Spec.—1-30—M. & T.—250 Blks

E 58055 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58055

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 15-21 ST., WARD)

2-FULL NAME Mabel Brown

(a) RESIDENCE NO. 435 ? Cumberland St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) 1908 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Haycock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) B. C. H.

15 Filed 6 16 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-12-30

17 I HEREBY CERTIFY, That I attended deceased from 1-30-30, 19..., to 6-12-30, 19..., that I last saw her alive on 6-12-30, 19..., and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis, chronic, rheumatic.

More than (duration) ...yrs. 6 mos ...ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic acute (duration) ...yrs. 5 mos. ...ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

6-14, 19 30 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAN

DATE OF BURIAL JUN 1 1930 19

20 UNDERTAKER Dep. Commissioner Health

ADDRESS

TION IS very important

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58056

CERTIFICATE OF DEATH

129

E 58056

1—PLACE OF DEATH

REGISTERED NO. 28-71

CITY OF BALTIMORE: (No. 433 Westgate Road ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hubert Andrew Strohmer

(a) RESIDENCE NO. 433 Westgate Road. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Strohmer

6 DATE OF BIRTH (month, day, and year) June 13-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Strohmer

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Germany.

12 MAIDEN NAME OF MOTHER Rosalie ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Germany

14 Informant Theresa Strohmer

(Address) 433 Westgate Road.

15 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-15-1930

17 I HEREBY CERTIFY, That I attended deceased from March 17-, 1928, to June 15-, 1930, that I last saw h. alive on 6-9-, 1930 and that death occurred, on the date stated above, at 9:15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY None

(Secondary)

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Chester Riland, M. D.

6-15, 1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 17 1930
20 UNDERTAKER	ADDRESS
J. J. Fahey & Sons	1315 Light

Important: Use black ink.

Spec.—1-12-23—M&T—500 Bks.

E 58057

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58057

CERTIFICATE OF DEATH

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No.) 1000 Eaton Ave ST. 12-50 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernie M. Tighe

(a) RESIDENCE NO. 2227 Reed Ay ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James W. Tighe

6 DATE OF BIRTH (month, day, and year) Sept 12th 61

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Peter Sweeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Sharkey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Jenkins Memorial Hospital 1000 Eaton Ave

15 Filed 6 16 1930, 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to June 15, 1930, that I last saw h[illegible] alive on June 15, 1930, and that death occurred, on the date stated above, at 9-500 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) George Brewer, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 6/19/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of

1-30—M. & T.—100 B—50L

E 58058

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58058

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Wayside & Thomsen Sts ST., 9-12 WARD)

REGISTERED NO. 178

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Swift

(a) RESIDENCE NO 2443 Eager Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	divirced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella T.(Vanbokern)

6 DATE OF BIRTH (month, day, and year) Jan 30/1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	4	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mgr.
(b) General nature of industry, business, or establishment in which employed (or employer) Burlap etc
(c) Name of employer M.J.Swift, Inc.

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Luke Swift

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary J. Keith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Oliver E. Swift (Bro)
(Address) 436 E. 22nd St

15 Filed 6/16/30 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suffocation & Shock. Trapped on 3rd floor of burning bldg at Wayside & Thomsen Sts. June 14/30 Accident a

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Kaiser, M. D. Coroner

6/16/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 6/17 1930

20 UNDERTAKER W. M. Cook — ADDRESS 12 S. St. Paul St.

TION is very important. See instruction on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 58059 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58059

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 13-52

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Eigenbrodt

(a) RESIDENCE NO. 3448 Elm Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ..... da. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Dec. 19, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	5	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Paper carrier
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Eisenbrodt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Kroll

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant: Records of
(Address) Balto. City Hosp.

15 Filed JUN 16 1930, C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16-30

17 I HEREBY CERTIFY, That I attended deceased from 5-20-30, 19..., to 6-16-30, 19...,
that I last saw him alive on 6-16-30, 19...,
and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into
Ceycbyum
(duration) ... yrs. 6 mos ... da.

CONTRIBUTORY (Secondary) Myocoydits.
CHRONIC (duration) unknown. yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.
6-16, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. DATE OF BURIAL: June 18 1930

UNDERTAKER: Ehrenwerth Bros. ADDRESS: 360 Chestnut ave

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58060

CERTIFICATE OF DEATH.

154-002 E 58060

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2732 Huntingdon Ave. (If not in hospital, give ward) 47-51

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Infant Braun

(a) RESIDENCE NO. 2732 Huntingdon Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 15, 1930

7 AGE — Years: — Months: — Days: — IF LESS than 1 day 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Peter E. R. Braun

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Grebe

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant:

(Address):

Filed 1 6 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15 1930

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to June 15, 1930;

that I last saw h. im alive on June 15, 1930

and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows:

Foramen Ovale Not Closed

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Fair, M. D.

, 19 (Address) 2704 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden Date of Burial: Jun 17 19 30

20 UNDERTAKER: Chenoweth & Son ADDRESS 3417 Chestnut Ave

OF DEATH in pencil (ink), or type. Be very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 58061

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

6-29 11 7 E 58061

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Maryland Gen. Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Geo. Paul Hetz

(a) RESIDENCE NO. 1184 Washington Blvd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 11 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of Mrs G. P. Hetz

6 DATE OF BIRTH (month, day, and year) July 8 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. Paul Hetz

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Schad

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Hospital Records
(Address)

15 Filed ..... 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1930

17

I HEREBY CERTIFY, That I attended deceased from 6/11, 1930, to 6-15, 1930

that I last saw h. in alive on 6-15-, 1930

and that death occurred, on the date stated above, at 8¹⁵ A. m.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Paralytic ileus & dehydration

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 6-11-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical

Signed Wm A Stamper, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Pk. Mausoleum	6/18/1930

20 UNDERTAKER Harry Nitsche, ADDRESS 4101 Edmondson Ave.

C. HAMPSON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58062 — CERTIFICATE OF DEATH — 143-002 — E 58062

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 4-30 Ward)

2-FULL NAME Gladys E. Brohawn

(a) RESIDENCE NO. Linthicum P.O. A.A. County St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. G. Brohawn

6 DATE OF BIRTH (month, day, and year) Oct 12-1896

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
33	34	8	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Nelson W. Ward

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Bertie Dixon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Wm. G. Brohawn
(Address) Woodlawn Hgts

15 Filed JUN 6 1930 19 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, Autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Ectopic Pregnancy (left)

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Eugene Gilbert M. D.

6/16. 1930 (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	6/18/30

20 UNDERTAKER Harry A. Wyche ADDRESS 4401 Edmondson

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58063

CERTIFICATE OF DEATH

E 58063

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hospital St. 14-28 W. Balto)

2-FULL NAME Rose E. McKitrick

(a) RESIDENCE NO. 16 So Gilmor St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John McKitrick

6 DATE OF BIRTH (month, day, and year) Jan 24 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	73	4	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H W
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Moses Posnell

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Lamb

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs. Chas. H. Stone
(Address) 165 Johnson

15 Filed JUN 16 1930 (Signature) HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronch-Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brush M. D.

June 15, 1930 (Address) 3601 3 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem Elkridge City — DATE OF BURIAL 6/17/30

20 UNDERTAKER Harry H Wyke — ADDRESS 410 Eliason

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58064

CERTIFICATE OF DEATH.

129 E 58064

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1722 Druid Hill Ave WARD) 4-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Johnson

(a) RESIDENCE NO. 1722 Druid Hill WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alfred

6 DATE OF BIRTH (month, day, and year): Oct 4-1849

7 AGE — Years: 80 — Months: 8. — Days: 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer): 069

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Louis West

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Clove Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Nellie E Turner

(Address): 1722 Druid Hill Ave

C. HAMILTON BOWIE, M.D.

Filed 6-17-1930 per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to June 14, 1930, that I last saw h alive on June 13, 1930, and that death occurred, on the date stated above, at 2.15A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 6 mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) G Mckee, M. D.

(Address) 1126 Druid Hill 6-17 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington, D.C.

DATE OF BURIAL: 6/17/1930

20 UNDERTAKER: Mrs. Geo. H. Holland

ADDRESS: 1681 Druid Hill

N TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

E 58065 — 113 E 58065

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1342 Argyle St. 17-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosetta Stephens

(a) RESIDENCE NO. 1342 Argyle Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER William Stephens

11 BIRTHPLACE OF FATHER (city or town) S.C.

(State or country)

12 MAIDEN NAME OF MOTHER Ethel Norman

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant William Stephens

(Address)

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1930

17 I HEREBY CERTIFY, That I attended deceased from June 4 1930, to June 15 1930

that I last saw h. alive on June 15 1930

and that death occurred, on the date stated above, at 12 m.

THE CAUSE OF DEATH was as follows:

Infantile Convulsions

Bronchitis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Coleman M. D.

June 15 1930 (Address) 2039 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lion Cemetery — DATE OF BURIAL June 17, 1930

20 UNDERTAKER Mrs Kate R Williams — ADDRESS 322 N Schroeder St.

FRANK R. KIRKPATRICK, M. D. Registrar

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 58066

E 58066

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 608 Lafayette Ave WARD 14-20)

2-FULL NAME Mildred Thomas

(a) RESIDENCE NO. 608 Lafayette Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	C.	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12/28/29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) 608 Lafayette Ave
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel R. Thomas

11 BIRTHPLACE OF FATHER (city or town) Howard Co.
(State or country)

12 MAIDEN NAME OF MOTHER Martha Hall

13 BIRTHPLACE OF MOTHER (city or town) Montgomery Co
(State or country)

14 Informant Mary R. Thomas
(Address) 608 Lafayette Ave

15 Filed ..... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/30

17 I HEREBY CERTIFY, That I attended deceased from 6/15/30, to 6/15/30.
that I last saw h— alive on 6/14/30, at 8:55 P.M.
and that death occurred, on the date stated above, at 8:55 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) ..... yrs. mos. 21 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Allen, M. D.

(Address) 722 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	June 17 1930
20 UNDERTAKER	ADDRESS 322 N.
Mrs. Katie R. Williams	Schroeder

CAUSES OF DEATH. See instructions on back of certificates. ATTENTION is very important.

Spec.—1-30—M. & T.—250 Bks.

E 58067 Mil-

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58067

CERTIFICATE OF DEATH.

X 129

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) JOHNS HOPKINS HOSPITAL St., 7-9 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Mayon

(a) RESIDENCE No. Mexico City St., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Realtor
(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10 NAME OF FATHER Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio.

12 MAIDEN NAME OF MOTHER [illegible] Cheney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio.

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16-30

17 I HEREBY CERTIFY, That I attended deceased from 2-9-, 1930, to 6-16-, 1930, that I last saw h[illegible] alive on 6-16-, 1930, and that death occurred, on the date stated above, at 2 50 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Chronic Nephritis, Coronary Sclerosis

(duration) 12 yrs. mos da.

CONTRIBUTORY (Secondary) Coronary occlusion Myocardial failure
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

June 16 1930 (Address) 1806 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cincinnati Ohio

DATE OF BURIAL June 17 1930

20 UNDERTAKER [illegible] Undertaking Co

ADDRESS 1806 Eutaw Place

Spec.—1-30—M. & T.—250 Bks

E 58068 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58068

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 16-22 ST. (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Plummer

(a) RESIDENCE NO. 1100 S. Stricker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Wisowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec. 19, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER James H. Plummer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Anna Davis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed 7-1-1930, 19 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16-30

17 I HEREBY CERTIFY, That I attended deceased from 3-10-30, 19, to 6-16-30, 19,

that I last saw h[illegible] alive on 6-16-30, 19,

and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchitis, chronic unknown.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padgett, M. D.

6-16, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL June 6 1930

UNDERTAKER Robt J. Turner ADDRESS 1422 N Broadway

Spec.—1-10-21—M&T—1500 Bks.

E 58069

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58069

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2951 Bernard St. (ST.) 17-51 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Franklin Fisher

(a) RESIDENCE NO. Westminster Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred + — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Agnes Fisher

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Westminster Md.
(State or country)

PARENTS

10 NAME OF FATHER John F Fisher

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Susan Mirley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Elmer Fisher
(Address) 2951 Bernard St Balto

Filed JUN 17 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1930

17

I HEREBY CERTIFY, That I attended deceased from June 12 1930 to June 17 1930;

that I last saw him alive on June 12 1930,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Susan Dwelle M.D.

6/17 1930 (Address) 846 W 36th St. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St John's Westminster June 19 1930

20 UNDERTAKER — ADDRESS

H Bankard & Son Westminster

SECTION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 58070 HEALTH DEPARTMENT—CITY OF BALTIMORE

89 ✓ E 58070

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 332 S. Collington Ave (WARD) 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Boyle Jr

(a) RESIDENCE No. 332 S. Collington ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. dys. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) M

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Araminta Boyle

6 DATE OF BIRTH (month, day, and year) Oct 9th 1846

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
83	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Shipping

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER John Boyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Jane Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant John Boyle Jr

(Address) 332 S. Collington Ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to June 14, 1930,

that I last saw him alive on June 13, 1930,

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Hypertension (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Senile Debility (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Heart Lesion

(Signed) [illegible], M. D.

19 (Address) 318 Elwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL 6/17 19 30

20 UNDERTAKER J. A. Inman

ADDRESS 3000 E Baltimore

Spec.—1-12-23—M&T—500 Bks.

E 58071

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58071

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 345 S. Macon (St.) 46-27 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Deloso

(a) RESIDENCE NO. 345 S. Macon ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Deloso

6 DATE OF BIRTH (month, day, and year) March 1 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER — Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Jose Mex 345 S. Macon St

15 Filed ....., 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan — , 1930, to June 15 1930, that I last saw h[illegible] alive on June 15, 1930, and that death occurred, on the date stated above, at 10.31 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs — mos — ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Morris J. Fahrendinger M. D.

19 (Address) 1514 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL June 18. 1930

20 UNDERTAKER Henry Sauter & Sons Inc

ADDRESS Baltimore St. & Broadway

Spec.—1-30—M. & T.—250 Bks.

E 58072

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 58072

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1910 W Mulberry ST., (or WARD) 90-27

REGISTERED NO. 90-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B Kemper

(a) RESIDENCE NO. 1910 W Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 10 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie E. Kemper

6 DATE OF BIRTH (month, day, and year) 7-19-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
74	75	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) " (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Miss Edith Kemper (Address) 1910 W Mulberry St

15 Filed 6 [illegible] 19 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16-30

17 I HEREBY CERTIFY: That I attended deceased from June 14 1930 to Jun 16 1930

that I last saw h[illegible] alive on Jun 14 - 1930

and that death occurred, on the date stated above, at 9 30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

6/16/30 (Signed) Billy O'Sullivan M. D.

(Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cemetery

UNDERTAKER E + B Harke 115 E

DATE OF BURIAL 6-18 1930

ADDRESS West St

Spec.—1-12-23—M&T—500 Blks.

58073

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58073

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 N. Carrollton ave 16-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Conaway

(a) RESIDENCE NO. 604 N. Carrollton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Donahan Conaway.

6 DATE OF BIRTH (month, day, and year) 10-18 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City.

PARENTS

10 NAME OF FATHER Wells Locks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ada Barnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs Ada Locks

(Address) 604 Carrollton ave

Filed 1 7 19 32 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-15- 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-13- 1930, to 6-15- 1930, that I last saw her alive on 6-14- 1930 and that death occurred, on the date stated above, at 5,10 A. m

The CAUSE OF DEATH* was as follows:

Carcinoma of Genitals

unknown. owl

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. Cargile, M. D.

6-16, 1932 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem

DATE OF BURIAL June 17th 1930

20 UNDERTAKER Mrs J. W. Locke

ADDRESS 1302 Jefferson

Spec.—1-30—M. & T.—250 Blks.

E 58074 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58074

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2503 W. Fairmount Ave ST. 20-69 WARD)

2-FULL NAME Sophia Tayman. Franklin.

(a) RESIDENCE NO. 2503 W. Fairmount Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Divorced.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Joseph C. Franklin.

6 DATE OF BIRTH (month, day, and year) Nov. 11, 1865.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
64.	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) - - - - -

(c) Name of employer - - - - -

9 BIRTHPLACE (city or town) (State or country) Prince George County, Md.

PARENTS

10 NAME OF FATHER John Tarpnan.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Ogle.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Harry E. Franklin. (Address) 2503 W. Fairmount Ave.

15 Filed ..., 19C. HARPER JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15-1930

17 I HEREBY CERTIFY, That I attended deceased from 6/10- 1930 to 6/15- 1930 that I last saw h alive on 6/15- 1930 and that death occurred, on the date stated above, at 8 30 A.m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis Hypertension

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardits

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas. H. Camp, M. D.

6/16, 1930 (Address) 2145 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Roseville, Prince George Md.	6/18/1930
UNDERTAKER	ADDRESS
F.B.Wippert - 1850 W. Baltimo	

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 58075

58075

CERTIFICATE OF DEATH

REGISTERED NO. 27-44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4716 Pilgrim Road ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adelaide West

(a) RESIDENCE NO. 4716 Pilgrim Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 0 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter West

6b DATE OF BIRTH (month, day, and year) June 8 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Theodore Balla

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ann Kemp

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Mrs. Johnson

(Address) 4716 Pilgrim Road

15 Filed JUN 17 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6.16.30.

17 I HEREBY CERTIFY, That I attended deceased from 6.7.30., 19..., to 6.16.30., 19...,

that I last saw h... alive on 6.15.30, 19...

and that death occurred, on the date stated above, at 2-P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ...yrs. ...mos. 1½ ds.

CONTRIBUTORY (Secondary) Acute Cholecystitis

(duration) ...yrs. ...mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Philip B. Fowler, M. D.

6.17.30. (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 6/18 1930

20 UNDERTAKER J. Tew McCully

ADDRESS 130 E. Fort

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58076

CERTIFICATE OF DEATH

E 58076

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Baltimore City Hospital Ward)

2-FULL NAME John Zaboamsky

(a) RESIDENCE NO. 4912 Curtis Ave., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. — mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Store-Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Pete Lisowsky 4920 Pennington Ave

15 Filed JUN 17 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Zeller, M. D.

6/16. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russian Independet	June 17 1930
20 UNDERTAKER	ADDRESS
John Grebliauckas	433 S Paca St

Important. See instructions on back of certificate.

Spec.--1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58077. 31 E 58077.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE—No. 771 W Saratoga St. 4-No (WARD)

2-FULL NAME John Edward Rose

(a) RESIDENCE NO. 771- W. Saratoga ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20- 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Canfield Lot

9 BIRTHPLACE (city or town) (State or country) Douglas Cowr

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Bryce Rose
(Address) 771 W Saratoga St

Filed 6-17-1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-15- 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-15-, 1930, to 6-15-, 1930.

That I last saw him alive on 6-14, 1930

and that death occurred, on the date stated above, at 10 30 p m.

The CAUSE OF DEATH was as follows:

Pulmonary Tuberculosis
Fibroid Type

(duration) yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hamilton Jones M. D.

6/16 1930 (Address) Boonsboro Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Field Lot

DATE OF BURIAL 6/17 1930

20 UNDERTAKER Emmett L. Hensley

ADDRESS Keedysville Md

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58078

60-001

E 58078

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caudand & Olwn ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mazie Schuckardt

(a) RESIDENCE NO. 1618 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced, HUSBAND of or) WIFE of Wm F. Schuckardt

6 DATE OF BIRTH (month, day, and year) Mar 22/1899

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
31	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jos. Dietz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm F Schuckardt Sr.

(Address) 1618 N. Washington St.

15 Filed 1 7 1930, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1930

17 I HEREBY CERTIFY That I attended deceased from June 9, 1930, to June 16, 1930.

That I last saw h.. alive on June 16, 1930.

and that death occurred, on the date stated above, at 1 55 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6-16-30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vincent Meyerson M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon P.R. Cem

DATE OF BURIAL June 19, 1930

UNDERTAKER Philip Henig

ADDRESS 2016 Eutaw St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58079

90 E 58079

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1517 Mt. Royal Ave ST. 14-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Willson

(a) RESIDENCE NO. 1517 Mt. Royal Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82 Yrs. ?		?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph E. Willson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary A. King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Miss Josephine A. Willson

(Address) 1517 Mt. Royal Ave.

15 Filed JUN 17 1930 C. H. WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to June 16, 1930, that I last saw her alive on June 15, 1930, and that death occurred, on the date stated above, at 7:10 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) Not definite yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Stanford, M. D.

6/17 1930 (Address) 1216 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	6/18/30 19

20 UNDERTAKER H. W. Greene & Son ADDRESS 105 N. Eden St.

Spec.—1-30—M. & T.—250 Blks.

E 58080 — 3/30?

HEALTH DEPARTMENT—CITY OF BALTIMORE — E 58080

CERTIFICATE OF DEATH.

Ped. — ×38

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 11-7 WARD)

2-FULL NAME Billy Rhodes

(a) RESIDENCE NO. 605 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	child.

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4/21/30

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
		7	25	
		7 weeks		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (0)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Rhodes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Blanche Carney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records. (Address) JOHNS HOPKINS HOSPITAL

15 Filed 7-1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16-30

17 I HEREBY CERTIFY, That I attended deceased from 5-23-, 1930, to 6-16-, 1930, that I last saw him alive on 6-16, 1930, and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis, Septicemia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Congenital syphilis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J W Bickford, M. D.

6/16, 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL 6/18 1930

UNDERTAKER Wm. G. Schaffe

ADDRESS 18 E. Monument St

Spec.—1-10-21—M&T—1500 Blks.

E 58081 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58082

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St. 25-12 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma Adams

(a) RESIDENCE NO. Emmitsburg Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Adams

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Ed Adams (Address) Emmitsburg Md

15 Filed JUN 17 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1930

17 I HEREBY CERTIFY, That I attended deceased from June 9- 1930 . to June 17 . 1930 .

that I last saw h alive on June 17 . 1930 ,

and that death occurred, on the date stated above, at 10.25 a m. Standard Time

The CAUSE OF DEATH* was as follows:

chronic myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brawner, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmitsburg Md

DATE OF BURIAL June 18 1930

20 UNDERTAKER M. L. Shuff Jr Emmitsburg Md

ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 58082 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58082

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3010 White ave (St.) 27-43 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabelle D. Arnendt

(a) RESIDENCE No. 3010 White ave St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian P. Arnendt

6 DATE OF BIRTH (month, day, and year) March 8th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (City or town) Balto.
(State or country) Maryland

PARENTS

10 NAME OF FATHER George L. Campbell

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Shroud

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Christian P. Arnendt
(Address) 3010 White Ave.

15 6-1-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1930

17 I HEREBY CERTIFY, That I attended deceased from May, 1927, to June 15, 1930, that I last saw h[illegible] alive on June 14, 1930, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) .....
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Voss, M. D.

6/16, 1930 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 18 1930
20 UNDERTAKER Fred'k Lasalmonia & Son	ADDRESS Fullerton

Spec.—1-30—M. & T.—250 Bks.

E 58083

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58083

CERTIFICATE OF DEATH.

23-32 57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Race ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Thomas.

(a) RESIDENCE NO. 1619 Race. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widowed.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael J. Thomas.

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1861.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69.	6.	15.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) England.
(State or country)

PARENTS

10 NAME OF FATHER Peter Grill.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Martinsburg, Va.

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England.

14 Informant Theresa Sheidt, (Daughter).
(Address) 1619 Race St.

15 Filed ....., 19 C. HAMPSON JONES, M. D.
Registrar

1 71830

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1930

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 16, 1930,

that I last saw her alive on June 16, 1930,

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

Indefinite

(duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 2 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) [illegible] M. D.

6/17, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Lethedale Cem.

DATE OF BURIAL June 20, 1930

20 UNDERTAKER C. Howard Evans

ADDRESS 35 E. Fayette

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58084

CERTIFICATE OF DEATH

E 58084

REGISTERED NO. 47

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hosp. ST. 345 WARD 15) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Agnes Lambert

(a) RESIDENCE NO. 3709 Fourth ST., Brooklyn Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 8 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Lambert

6 DATE OF BIRTH (month, day, and year) Sept 22. 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Nathaniel Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Budget Pendegrast

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Conway

(Address) 3709 Fourth St. (Brooklyn)

15 Filed JUN 19 1930 HANSON JONES, M.D. Registrar

N 18130

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from 6/5, 1930, to 6/16, 1930

that I last saw h alive on 6/16, 1930

and that death occurred, on the date stated above, at 6:45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) yrs. 7 mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 6/10/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam

(Signed) Theo. E. Stacy Jr., M. D.

, 19 (Address) Bon Secours Hosp Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL June 19 1930

ADDRESS 1422 Light St.

20 UNDERTAKER Margaret A. Flynn

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58085 — REGISTERED NO. E 58035

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4306 Raspe ST. 26-42 WARD 90)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Winifred M. Kidwell

(a) RESIDENCE NO. 4306 Raspe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm a. Kidwell

6 DATE OF BIRTH (month, day, and year) July 26 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	29	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Meehan McHale.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ann McGaha.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Wm a. Kidwell (Address) 4306 Raspe ave

15 Filed JUN 19 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 19 1930 to June 15 1930

that I last saw h alive on June 15 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation (Decompensated)

(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Thos. F. a. Stevens, M. D.

6/19 1930 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL June 18 1930

20 UNDERTAKER Margaret D. Flynn — ADDRESS 1422 Light

Spec.—1-30—M. & T.—250 Blks

E 53086

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53086

CERTIFICATE OF DEATH.

REGISTERED NO. 99

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1850 N Collington Ave (St.) (Ward) 26-16

2-FULL NAME Edward J. Dairs

(a) RESIDENCE NO. 1850 N Collington Ave (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 29 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Dairs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Trojanowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) Mr Joseph Dairs 1850 N. Collington Ave

15 Filed JUN 18 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1930, to June 17, 1930, that I last saw him alive on June 16, 1930, and that death occurred, on the date stated above, at 2:00 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. 1 mos. 4 da.

CONTRIBUTORY (Secondary) O/K Laureston

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Examination

(Signed) Albert E. Burnley, M. D.

6/17 1930 (Address) 2025 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	June 18 1930
20 UNDERTAKER J. W. Ozazeski	ADDRESS 1930 Eastern Ave

Spec.—1-30—M. & T.—250 Blks.

Suit

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58087 E 58087

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals. REGISTERED NO. .....
(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto md. ST. 76-27 WARD)

2-FULL NAME Peter Smith

(a) RESIDENCE NO. 3734 Fleet St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Laura Smith

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57 56				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 015

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Denis Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Record Balto City Hosps
(Address)

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

B 1030

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-15-30

17 I HEREBY CERTIFY, That I attended deceased from 7-12-, 19 29, to 6-15, 19 30,
that I last saw him alive on 6-15-, 19 30,
and that death occurred, on the date stated above, at 9.40 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure Senile &
Arteriosclerotic Heart Disease
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Senile Psychosis - Confusional
Deterioration (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical course

(Signed) Jerry F. Sullivan M. D.

6/16, 19 30 (Address) Baltimore City Hosps.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem. DATE OF BURIAL June 18 1930

20 UNDERTAKER John Ulrich ADDRESS 2008 Allens

Spec.—1-10-21—M&T—1500 Bks.

E 58088

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58038

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 262 S Monastery Ave. 70-11 WARD)

2-FULL NAME Mattie Jane Kendall

(a) RESIDENCE NO. 262 S Monastery ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chastner S Kendall

6 DATE OF BIRTH (month, day, and year): Aug 8 1864

7 AGE: Years 65 Months 10 Days 17

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wales

PARENTS

10 NAME OF FATHER: Jonathan Wales

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wales

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wales

14 Informant (Address): Mrs L Kendall 262 Monastery Ave

15 Filed 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 1930

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to June 17, 1930, that I last saw her alive on June 16, 1930, and that death occurred, on the date stated above, at 1.05 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast (Right)

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary): General Carcinomatosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 1926

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Pathological

(Signed) Elliot W. Johnson, M. D.

, 19 (Address) 3326 Frederick ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: June 19 1930

20 UNDERTAKER: John Allen

ADDRESS: 2008 Eutaw

TION is very important. See instructions on back of Certificate

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58089

REGISTERED NO. E 58089

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 58089
1-PLACE OF DEATH

City of Baltimore: (No. Union Memorial Hosp. St., 27 Ward)

2-FULL NAME Mr. John-Betschler

(a) RESIDENCE NO. 7613 Wallis St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ida Gugel Betschler

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	64	7	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Green-keeper
(b) General nature of industry, business, or establishment in which employed (or employer) M. E. Club
(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John-Betschler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Carlie Betschler
(Address) 7613 Wallis ave

Filed JUN 8 1930 E. HARRISON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto which he was driving collided with street car

(duration) yrs. mos. ds.

Fract. Skull

CONTRIBUTORY (Secondary) Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Prince Georges County Hospital

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E. J. Frain, M. D.

6/16 1930 (Address) 2939 - Mc Elderry.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	June 18 1930
20 UNDERTAKER John. C. Mitchell	ADDRESS Frederick Md

Important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

58090

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167-001

E 58090

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 665 W. Fayette St. 425 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Zellner

(a) Residence No. 665 W. Fayette St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 12, 1930

7-AGE. .....yrs. .....mos. .....ds. If LESS than 1 day, 3½ hrs. or .....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) Baltimore
(State or Country),

PARENTS.

10-NAME OF FATHER, Edwin Henry Zellner

11-BIRTHPLACE OF FATHER (city or town) Allentown, Pa.
(State or Country),

12-MAIDEN NAME OF MOTHER, Virginia Stutts

13-BIRTHPLACE OF MOTHER (city or town) W. Va.
(State or Country),

14- (Informant) C. C. Shaw

(Address) University Hospital

Dec 8 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 12, 1930

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1930 to June 12, 1930 that I last saw him alive on June 12, 1930 and that death occurred, on the date stated above, at 6.00 A.M.

The CAUSE OF DEATH* was as follows:

Premature - 8 mos.

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Premature separation

(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

6/17/1930 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. — DATE OF BURIAL, ...19....

20-UNDERTAKER. Commissioner of Health. ADDRESS

JUN 17 1930

UNIVERSITY OF MARYLAND

Spec.—1-30—M. & T.—250 Blks.

58091 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 9VE 58091

1-PLACE OF DEATH Sinai Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 6-9 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Israel Leon

(a) RESIDENCE NO. 291 N. Eden St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Rose Leon

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hebrew teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Rose Leon (Address) 1439 E Balto St

15 Filed JUN 18 1930 H. A. KELLY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930 to June 17, 1930, that I last saw him alive on June 17, 1930, and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. 1 mos da.

CONTRIBUTORY (Secondary) Arteriosclerosis

? (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) Milton B. Kirsh, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 6-18-1930

UNDERTAKER Jack Lewis, 1439 E Balto St.

ADDRESS

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58092 ✓ 101-001 E 58092

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST. 44-59 WARD

2-FULL NAME Dolores Rice

(a) RESIDENCE NO 2205 Etting ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25/1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	8	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Talcum Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elizabeth Rice

(Address) 2205 Etting St

15 Filed ..... 192 ..... Registrar

N 18 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia (Prob Lobar)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. H. Gee, M. D. Coroner

6/18/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Calvary

DATE OF BURIAL June 19

20 UNDERTAKER Thomas E Kelly

ADDRESS 893 Presstman

Spec.—1-12-23—M&T—500 Bks.

E 58093

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58093

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2415 Pine ST. 25-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A Publow

(a) RESIDENCE No. 2415 Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Publow

6 DATE OF BIRTH (month, day, and year) 1884 Aug 6

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Publow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Frances Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mamie Publow

(Address) 2415 Pine St

15 Filed JUN 18 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1930, to June 16, 1930, that I last saw him alive on June 16, 1930, and that death occurred, on the date stated above, at 1 10 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) R. J. Gilmore, M. D.

June 17, 1930 (Address) 2703 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL June 19 1930

20 UNDERTAKER Eugene A. Bortz — ADDRESS 1422 N Carey

sc.—1-30—M. & T.—250 Blks.

237555

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58094

E 58094

CERTIFICATE OF DEATH.

REGISTERED NO. 123

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Piggins

(a) RESIDENCE NO. Glenburnie Md ST., WARD

(Usual place of abode) c/o John P. Matthews

Length of residence in city or town where death occurred yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Walter

6 DATE OF BIRTH (month, day, and year) 6-27-75

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home-work

(b) General nature of industry, business, or establishment in which employed (or employer): — 037

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Wiener

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Simpson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1 6 1930, 19 H. AMY JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-17-30

17 I HEREBY CERTIFY, That I attended deceased from 6-1-, 1930, to 6-17-, 1930,

that I last saw h.r alive on 6-17-, 1930,

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Chole-lithiasis

Peritonitis

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 6/7/30

Removal of gall bladder

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I. R. Trimble M.D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md DATE OF BURIAL June 19 1930

20 UNDERTAKER Stewart & Mann Co Bals ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58095

CERTIFICATE OF DEATH

E 58095

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 N. Pine ST. 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ann Louise Fry

(a) RESIDENCE NO. 428 N. Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 2, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster, Md

PARENTS

10 NAME OF FATHER Shriner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louise Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Naylor

(Address) 428 Pine St.

15 Filed JUN 16 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/30

17 I HEREBY CERTIFY, That I attended deceased from 2/1, 1930, to 6/15, 1930, that I last saw her alive on 6/14, 1930, and that death occurred, on the date stated above, at 10.40 A. m. Standard Time

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. S. Hartman M. D.

6/18, 1930 (Address) 912 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olive Cem

DATE OF BURIAL June 18 1930

20 UNDERTAKER Samuel H. Stansbury

ADDRESS Pimlico

1-30—M. & T.—100 B—50L

E 58096

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-001

E 58096

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. near Harford Ave & 26th St. 18-26

2-FULL NAME Myer Friedman

(a) RESIDENCE NO 1119 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27/1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	0	20 19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 0 10
(c) Name of employer

9 BIRTHPLACE (city or town) Warsaw
(State or country) Russia

PARENTS

10 NAME OF FATHER Benj. Friedman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant U.S.V.B. Records
(Address)

15 Filed 6-30-92 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull (occiptail region)
Struck by bridge while stealing ride on top box car B & O R R At Harford Ave & 26th St. Accidental

(duration) yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jos. Collins, M. D.
Coroner

6/17/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 6/18/1930

UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 Balto st

Spec.—1-30—M. & T.—250 Bks.

E 58097 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58097

65-007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (NO. ..... ST. 2-4 ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman J. Amelung

(a) RESIDENCE NO. 1828 E. Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Martha E. Amelung

6 DATE OF BIRTH (month, day, and year) Feb 7, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40		4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stopper Polisher

(b) General nature of industry, business, or establishment in which employed (or employer) Arundell 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frederick Amelung

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Martha E. Amelung
(Address) 1828 E. Lombard St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

BLTR 1630

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16th, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 11th, 1930, to June 16th, 1930,

that I last saw him alive on June 16th, 1930,

and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Hodgkins disease

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & biopsy

(Signed) Louis B. Friedman, M. D.

June 16th, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL June 19, 1930.

20 UNDERTAKER Mr. & Mrs. John W. Tempel & Son — ADDRESS 801 W. Fayette

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58098

CERTIFICATE OF DEATH

101-001

E 58098

1—PLACE OF DEATH Franklin Sq. Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST 24-33 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Goble

(a) RESIDENCE NO. 331 E. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Gobel.

6 DATE OF BIRTH (month, day, and year) Feb. 19 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker.

(b) General nature of industry, business, or establishment in which employed (or employer) Md. Ship Yard

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10 NAME OF FATHER Wm Gobel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ill.

12 MAIDEN NAME OF MOTHER Isabella Gobel.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ill.

14 Informant Lillian Gobel.

(Address) 331 E. Hamburg

15 1 8 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 17th, 1930, to June 17th, 1930, that I last saw h. alive on June 17th, 1930 and that death occurred, on the date stated above, at 2 45 P.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No Clinical findings + lab

What test confirmed diagnosis?

(Signed) Arthur Rattenni, M. D.

6/17, 1930 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Cemetery Newport. Va.

DATE OF BURIAL June 19. 1930.

20 UNDERTAKER Fred R. Warner & Son.

ADDRESS 703 Hanover

Spec.—2-29-28—1. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58099 — CERTIFICATE OF DEATH — 49 E 58099

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 Clifton wood ST. 9-45 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edna E. Walzl.

(a) RESIDENCE NO. 2015 Clifton wood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): married

a If married, widowed, or divorced: HUSBAND of (or) WIFE of Wm. P. Walzl

6 DATE OF BIRTH (month, day, and year) Nov 17 1898

7 AGE: 32 Years 31 Months 6 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John H Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Margret Heidelmeier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Wm P Walzl

(Address) 2015 Clifton wood Ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 '30

17 I HEREBY CERTIFY, That I attended deceased from Apr 10 '30 to June 16, 1930,

that I last saw h alive on June 15, 1930

and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH was as follows:

Carcinoma of lungs

+ Cervical glands

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of breast

(duration) yrs. 15 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/10/30

Was there an autopsy? No

What test confirmed diagnosis? Microscopic exam

(Signed) J Bauerhaus, M. D.

6/17/30 (Address) 1901 Eutaw Pl

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: June 19 1930

20 UNDERTAKER: Robt J. Turner — ADDRESS: 1442 W. Broadway

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58100 | 191 | E 58100

CERTIFICATE OF DEATH

1-PLACE OF DEATH Pronounced dead Franklin Square Hospital — REGISTERED NO.

City of Baltimore: (No. 4-25 S[illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Salvatore Vassallo

(a) RESIDENCE NO. 127 N. Pearl St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residenre in rity or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da:

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divoreed, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
44y	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (rity or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or rountry) Italy

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town)
(State or rountry) Italy

14 Informant Police
(Address)

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

JUN 1929

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, Autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pistol Shot of brain
Fracture Base of Skull
Homicide

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooks M. D.

6/5. 1930 (Address) 3601 3 W

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Arridental, Suiridal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE OF BURIAL 19

20 UNDERTAKER [illegible] Board of Health

ADDRESS JUN 1 8 1930

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58101

E 58101

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (S.) 16-22 (WARD)

REGISTERED NO. 16-081

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Pitts

(a) RESIDENCE NO. 915 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	Inf.

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15-1930

7 AGE	Years	Months	Days	If LESS than 1 day ..hrs. or ..min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inf

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Leslie Pitts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed JUN 18 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/30

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to June 15, 1930,

that I last saw him alive on June 15, 1930,

and that death occurred, on the date stated above, at 4.25 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 10 hrs

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 6/15/30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. W. Bickford, M. D.

6/15, 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER [illegible] Health

ADDRESS JUN 18 1930

Spec.—1-30—M. & T.—250 Blks.

E 58102

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58102

CERTIFICATE OF DEATH.

REGISTERED NO. 16-902

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2325 Bond St. ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Kmiotek

(a) RESIDENCE No. 2322 E. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18-1930

7 AGE	Years	Months	Days	If LESS, than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Alexander Kmiotek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Veronica Pawlak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant

(Address)

15 JUN 18 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18-1930

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1930, to June 18, 1930, that I last saw h[illegible] alive on June 18 1930, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

a. Intrauterine Asphyxiation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Breech Presentation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S.

(Signed) John L. Szpulicki M. D.

(Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JUN 18 1930

20 UNDERTAKER

M[illegible] Bureau of Vital Statistics, Health.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58103

CERTIFICATE OF DEATH

129 E 58103

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3425 Elliott ST. 26-1 WARD)

2—FULL NAME THOMAS F. ALLEN

(a) RESIDENCE NO. 3425 Elliott ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Allen

6 DATE OF BIRTH (month, day, and year) October 15, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Overseer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 8 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Thomas Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Margaret Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mrs. Rose Allen (Wife)

(Address) 3425 Elliott Street

15 June 17 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17.1930

17 I HEREBY CERTIFY, That I attended deceased from 5/5/30, 19..., to 6/17, 1930, that I last saw h.. alive on 6/17/30, 19..., and that death occurred, on the date stated above, at 2.00 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis, and interstitial nephritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. H. Gonell, M. D.

6/17, 19 30 (Address) 633 S. Conkling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Govanstown Presbyterian Cemetery

DATE OF BURIAL June 19, 1930

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS Baltimore & Broadway.

Spec.—1-30—M. & T.—350 Blks.

E 58104 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 126 E 58104

CERTIFICATE OF DEATH. X

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 6 WARD 9)

2-FULL NAME John C. Wilson

(a) RESIDENCE NO. 212 Bond St, Belair, Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Edna L Moore Wilson

6 DATE OF BIRTH (month, day, and year) Apr 17- 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto repairs

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chas H Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Edna L Wilson
(Address)

15 [illegible] 19 HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18-1930

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1930, to June 18, 1930, that I last saw her alive on June 18, 1930 and that death occurred, on the date stated above, at 4.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Empyema (right) with secondary subphrenic abscess and pericarditis
(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Myocardial failure (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of June 15 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Vernon H Redman M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns Belg Co. Md

DATE OF BURIAL Jun 21 1930,

20 UNDERTAKER Dean & Jones

ADDRESS Bel Air, Md

Spec.—1-30—M. & T.—250 Blks

Dr. Eisenberg
2077 E North Ave

E 58105 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58105

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 E. North Ave ST.) 8-16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia A. Burns

(a) RESIDENCE NO. 2225 E. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Burns

6 DATE OF BIRTH (month, day, and year) March 6, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER A. Biermann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Adeline Whitzman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Walter Burns

(Address) 2225 E. North Ave

15 Filed JUN 18 1930, 19 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from February 4, 1929 to June 18 1930.

that I last saw her alive on June 17, 1930,

and that death occurred, on the date stated above, at 3:45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Articular Rheumatism

Chronic Interstitial Nephritis

Arterial Hypertension

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia + Exhaustion

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) [illegible] M. D.

6/18 1930 (Address) 2225 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL June 21 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 N Paca

Spec.—1-30—M. & T.—250 Bks.

E 58106

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 58106

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1624 E. 29th ST. 9-46 (WARD)

2-FULL NAME Pauline Elizabeth Bowers

(a) RESIDENCE NO. 1624 E. 29th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced (or) WIFE of: Geo. Bowers

6 DATE OF BIRTH (month, day, and year): Feb. 13th 1870

7 AGE: Years 60 | Months 4 | Days 4 | If LESS then 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Adolph Bergemeister

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Scharfenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Geo. Bowers (Address) 1624 E. 29th St.

15 Filed 6/18/30 G. HAMPSON JONES, M. D. Registrar

181030

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to June 17, 1930, that I last saw her alive on June 16, 1930, and that death occurred, on the date stated above, at 4:25 a.m.

The CAUSE OF DEATH* was as follows:

Cause of Liver

(duration) 1 yrs. 6 mos ' ds.

CONTRIBUTORY (Secondary): Brights disease

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Apr 4 1930

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Fred L. Emmert M.D.

(Address) 2857 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL 6/20/1930

20 UNDERTAKER: E. J. Fleming & Son - 1918 E. Lafayette Ave.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58107 111-001 ✓ E 58107

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH U.S. Marine Hospital, Baltimore, Md. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 2-4 WARD)

2—FULL NAME Thomas Moore

(a) RESIDENCE NO. The Anchorage, Balto., Md. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	0	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) Seaman
(c) Name of employer SS

9 BIRTHPLACE (city or town) Liverpool
(State or country) England

PARENTS

10 NAME OF FATHER Timothy Moore

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Mackin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Records, U.S. Marine Hospital
(Address) Baltimore, Md.

15 Filed 8 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from February 10, 19 30, to June 18, 19 30, that I last saw him alive on June 18, 19 30 and that death occurred, on the date stated above, at 3:30 A.m.

The CAUSE OF DEATH* was as follows:

Ulcer of stomach

unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema Less than 1 day
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 6-16-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab. findings

(Signed) [signature], M. D.

6/18, 19 30 (Address) U.S. Marine Hospital, City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's, Hampden — DATE OF BURIAL June 19, 1930

20 UNDERTAKER E. Leroy Stiffler, Inc. — ADDRESS 125 E. North ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58108

CERTIFICATE OF DEATH

185 E 58108

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital 27-44 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johanna Michel

(a) RESIDENCE NO. 4208 Harford Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Michel

6 DATE OF BIRTH (month, day, and year) Aug 3rd 1849

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	80	10	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Valet Weber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Milton Grief
(Address) 4208 Harford Road

15 Filed ..... 193.... C. HAMPSON JONES M. D. Registrar

8 1930 Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) June 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: (over)

Fracture of left femur.

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

6/16. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Con June 19	1930
20 UNDERTAKER	ADDRESS
John C. Miller	2135 E Alison ave

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58109

CERTIFICATE OF DEATH

44 ✓

E 58109

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 5907 Kavon Avenue ST. 26-42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William R. Maggio

(a) RESIDENCE NO. 5907 Kavon Avenue ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Adella E. Maggio

6 DATE OF BIRTH (month, day, and year) March 6, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Salvatore Maggio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Francesca Fulco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs. Adella E. Maggio

(Address) 5907 Kavon Ave.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

1 9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1930, to June 16, 1930

that I last saw him alive on June 16, 1930

and that death occurred, on the date stated above, at 5.35 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Sys. (Paresis)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray - Wasserman

(Signed) Chas Jones, M. D.

June 16 1930 (Address) 4706 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 19 1930
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 West W. Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58110 — 31 — E 58110

1—PLACE OF DEATH 807 Fremont Ave — REGISTERED NO. .....

CITY OF BALTIMORE: (No. 21-31 ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dora Griffin

(a) RESIDENCE NO. 807 Fremont ST., ... WARD (Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of: Charles Griffin

6 DATE OF BIRTH (month, day, and year): June 18 1888

7 AGE: 42 Years 10 Months 29 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): N. C

PARENTS

10 NAME OF FATHER: Charles Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: Matilda Hennon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C

14 Informant: Charles Griffin

Address: 807 E. Fremont Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17-30

17 I HEREBY CERTIFY, That I attended deceased from June 1 19 30 to June 17 19 30

that I last saw her alive on June 17 19 30

and that death occurred, on the date stated above, at 4 00 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. M. Hatcher, M. D.

6/18 19 30 (Address) 1718 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn St — DATE OF BURIAL: June 20 1930

20 UNDERTAKER: A. K. Brown's Son — ADDRESS: 1019 W. Mount St

JUN 19 1930 HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

E 58111

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58111

E 58111

CERTIFICATE OF DEATH

REGISTERED NO. 47

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Ward ST. 21-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Stewart

(a) RESIDENCE NO. 1411 Ward ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles D. Stewart

6 DATE OF BIRTH (month, day, and year): Nov 4 1872

7 AGE: Years 57 | Months 1 | Days 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work 37

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Nelson Nottingham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Charles D. Stewart

(Address): 1411 Ward St

15 Filed JUN 19 1930, 19 — HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1929, to June 17, 1930, that I last saw h[illegible] alive on June 16, 1930 and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Ductal Carcinomata

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 10/29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. McCard, M. D.

6/7, 1930 (Address) 2029 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Ct

DATE OF BURIAL: June 20 1930

20 UNDERTAKER: W. K. Brown & Son

ADDRESS: 108 W. Monday St

Spec.—1-30—M. & T.—250 Blks.

58112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓

E 58112

1-PLACE OF DEATH Baltimore City Hospitals (T. B.) ST 11-24 WARD)

CITY OF BALTIMORE: (NO. ..... ST ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Lee

(a) RESIDENCE NO. 1030 Linden ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
34 35		11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baggage porter

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Robert Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Mary McCoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Records
(Address)

Filed 9-1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1930, to June 17, 1930, that I last saw h. im live on June 17, 1930, and that death occurred, on the date stated above, at 6.25 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos 12 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) [signature] M. D.

6-17 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL June 19 1930

20 UNDERTAKER Samuel I. Newsley ADDRESS 578 N Bdle

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58113

CERTIFICATE OF DEATH.

REGISTERED NO. E 58113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Ethey st ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Simpson Sr.

(a) RESIDENCE. NO. 1124 Ethey st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 28 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carolina

PARENTS

10 NAME OF FATHER Henry Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ann Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Henry Simpson Jr

(Address) 1124 Ethey St

15 FILED JAN 19 1930 WILLIAM H. JONES, M. D. Registrar

Fal

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1930

17 I HEREBY CERTIFY, That I attended deceased from 6-3-, 1929, to 6-1-, 1930, that I last saw h[illegible] alive on Jan 15, 1930 and that death occurred, on the date stated above, at 4.40 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Hypertension & Hardening (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? L

Did an operation precede death? No Date of L

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

6-1-, 1930 (Address) 117 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL 6/31/ 1930

20 UNDERTAKER: Samuel Hemsley 5781 Reisterstown Rd — ADDRESS

THIS is very important. See instructions on back.

Spec.—1-10-21—M&T—1500 Bks.

E 58114

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58114

CERTIFICATE OF DEATH.

145

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST. 18-16 WARD)

2-FULL NAME Lillian Potter

(a) RESIDENCE NO. 1020 Hollins ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE: Years 35 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 031

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Simon Roman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Berman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Simon Roman Reidsville, N. C.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. [illegible]

JUN 19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1930

17 I HEREBY CERTIFY, That I attended deceased from June 13 1930 to June 18 1930.

that I last saw her alive on June 18 1930.

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolus

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Cesarean Section

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of June 13-1930

Was there an autopsy? no Clinical.

What test confirmed diagnosis? .....

(Signed) M. Alexander Novey M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (i) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd

DATE OF BURIAL 6/19 1930

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto St

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 58115

E 58115

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3712 Hickory Ave ST. 13-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William F. Dosh

(a) RESIDENCE NO. 3712 Hickory Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah C. Dosh

6 DATE OF BIRTH (month, day, and year): July 7-1862

7 AGE: Years 67 | Months 11 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: William Dosh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Hawthorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Mrs Sarah C Dosh

(Address) 3712 Hickory Ave

15 Filed: JUN 19 1930 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18 30

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1930, to June 18, 1930,

that I last saw him alive on June 8, 1930

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy,

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) C W Dickinson, M. D.

June 18, 1930 (Address) 2 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Littlestown Pa

DATE OF BURIAL: June 21 1930

20 UNDERTAKER: H S Marshall

ADDRESS: 359 Fallsway

Spec.—8-16-29—L. F. S.—100 Blks.

E 58116

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58116

CERTIFICATE OF DEATH

REGISTERED NO. 44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2806 Philadelphia Ave ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Kutchera (Kucera)

(a) RESIDENCE NO. 2806 Philadelphia Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: James Kutchera

6 DATE OF BIRTH (month, day, and year): Dec. 25, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

037

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Lenton Marowsek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Veronica Kabrina

11 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Josephine A. Burke

(Address): 2806 Phila Ave

15 Filed: JUN 19 1930 C. HAMPSON JONES, M. D. Registrar

N 19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1930 to June 18, 1930, that I last saw h[er] alive on June 17, 1930 and that death occurred, on the date stated above, at 10-15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mar. 6, 1930

Was there an autopsy? No

What test confirmed diagnosis? Duration & Path. Specimen

(Signed) Vincent K. Dooka, M. D.

19 (Address) 845 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill

DATE OF BURIAL: June 21 1930

20 UNDERTAKER: Frank Brockman

ADDRESS: 1716 Orleans Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 58117

REGISTERED NO.

E 58117

1-PLACE OF DEATH

City of Baltimore: (No. 157 East St. St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Body.(C)

(a) RESIDENCE NO. 157 East St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ---- How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Widower.

5a If ~~single~~, widowed, ~~wife of~~ HUSBAND of ~~XXXXXXX~~ Lele Body.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	46	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina.
(State or country)

PARENTS

10 NAME OF FATHER Alanzo.Gavin.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina.

12 MAIDEN NAME OF MOTHER Clara Gregory.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina.

14 Informant John Gavin.(C) brother.
(Address) 157 East St.

15 Filed ... 19... C. HAMILTON JAMES, M. D. Registrar
By ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardiat Insufficiency.

Acute dilatation of the Heart.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

6/19, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Calvary Cem January 1930

20 UNDERTAKER — ADDRESS

J. Albert Wallace 1458 Edgewood

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58118

CERTIFICATE OF DEATH

90 E 58118

1—PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1618 Cliftview Ave. WARD 8th)

2—FULL NAME Emma. F. Maguire

(a) RESIDENCE NO. 1618 Cliftview ST., Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced, (write the word)~~: Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John. F. Maguire

6 DATE OF BIRTH (month, day, and year): July 5 1867

7 AGE: Years 62 | Months 11 | Days 4 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore md

PARENTS

10 NAME OF FATHER: Robert. F. Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore md

12 MAIDEN NAME OF MOTHER: Mary V. Strugon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore md

14 Informant: John. F. Maguire
(Address) 1618 Cliftview Ave

15 Filed ... 19 ... C. HAMILTON JONES, M. D. Registrar

JUN 19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19 1930

17 I HEREBY CERTIFY, that I attended deceased from June 14 1930 to June 19 1930, that I last saw her alive on June 19 1930, and that death occurred, on the date stated above, at 3:15 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis deformans

Myocarditis

Thrombosis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of the heart

(duration) ... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) J. F. Maguire M. D.

19 (Address) 2147 Hartford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County

DATE OF BURIAL: June 21 1930

20 UNDERTAKER: Jos Joerdens & Son

ADDRESS: 217 S. Po...

Spec.—1-30—M. & T.—250 Bks

E 58119 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58119

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 5-8 ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Jones

(a) RESIDENCE NO. 333 Forrest ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Gotchmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed ..... 19 ..... C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-18-30

17 I HEREBY CERTIFY, That I attended deceased from 6-10-29, 19..., to 6-18-30, 19..., that I last saw him alive on 6-18-30, 19..., and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute.

Duration (duration) 1 yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? 1. Home. 2. in Hospital.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

6-19, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE- Greenmount

DATE OF BURIAL June 20 1930

20 UNDERTAKER Cook & Turner

ADDRESS 1 & 2 W. Baltimore

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58120 — 90 ✓ E 58120

CERTIFICATE OF DEATH

REGISTERED NO. 3814.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 703-N. Fremont ave ST 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ophelia Cunningham Pruett.

(a) RESIDENCE NO. 703-N. Fremont ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	Colored.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt. Henry Pruett.

6 DATE OF BIRTH (month, day, and year) Sept. 10, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Reistertown Maryland.

PARENTS

10 NAME OF FATHER Robt. Brown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Reistertown Maryland.

12 MAIDEN NAME OF MOTHER Ophelia C. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Reistertown Maryland.

14 Informant Emma Lyle (daughter)

(Address) 703-N. Fremont ave.

15 Filed JUN 19 1930 Emil HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to June 16, 1930, that I last saw h... alive on June 16, 1930 and that death occurred, on the date stated above, at 11:50 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardio-renal Disease

(duration) 1 yrs. 6 mos. 16 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory

(Signed) D. McK. Reesby, M. D.

19 (Address) 702-N. Carrollton ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Zion Cemetery	June 18 1930
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1725 Washington

Spec.—1-30—M. & T.—250 Bks

E 58121 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58121

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (Ward) 16-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Joshua Linton

(a) RESIDENCE NO. 1106 W Lafayette Ave (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Goldie Green

6 DATE OF BIRTH (month, day, and year) ~~Unknown 1850~~

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~46-50~~			18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister 016

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va (State or country)

PARENTS

10 NAME OF FATHER Nelson Green

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Minnie Jenkins

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Goldie Green

(Address) 1106 W. Lafayette Ave

Filed JUN 19 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-17-30

17 I HEREBY CERTIFY, That I attended deceased from 6-14-, 1930, to 6-17-, 1930, that I last saw him alive on 6-17-, 1930, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

Gangrenous

Generalized peritonitis.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6-14-30

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) A. L. Linton, M.D.

6/18, 1930 (Address) 6004 Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL June 20, 1930

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1215 Ashland Ave

Spec.—1-30—M. & T.—250 Bks.

Foster.

E 58122 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 40 E 58122

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 May ST., 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Foster

(a) RESIDENCE NO. 1124 May ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Henry Foster

6 DATE OF BIRTH (month, day, and year) Autumn 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Thomas Barrett

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Susan Watson

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Florence Watson

(Address) 1124 May St. M.

15 Filed HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18-30

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1930, to June 18, 1930, that I last saw h.. alive on June 18, 1930, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cardio Renal Disease

(duration) yrs. 1 mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) no M. D.

June 19 30 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn.

DATE OF BURIAL June 21, 1930

UNDERTAKER Mrs R. G. Elliott

ADDRESS 1225 Ashland Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58123

101-001

E 58123

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 W Lanvale St.; 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Peirce Bruns

(Residence in Baltimore: No. 132 W Lanvale St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, November (Month), 1 (Day), ... (Year)

7-AGE, about 59 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), New Orleans.

PARENTS.

10-NAME OF FATHER, John D. Bruns.

11-BIRTHPLACE OF FATHER (State or Country) New Orleans.

12-MAIDEN NAME OF MOTHER Mary Dickeson

13-BIRTHPLACE OF MOTHER (State or Country), New Orleans.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. R. McNulty

(Address) 132 W. Lanvale St.

15- C. HAMPSON JONES, M. D.

(Residence) 1 W. Mt. Vernon Pl.

JUN 19 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH June (Month), 18th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1930, to June 18 1930, that I saw h[illegible] alive on June 18 1930, and that death occurred, on the date stated above, at 11.15 P.M.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia
Acute Cardiac Dilatation
.....
..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

..... (Duration) 4 yrs. ..... mos. ..... ds.

(Signed) Frank S. Handley M. D.

June 18, 1930. (Address) 25 E. Mount St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem

DATE OF BURIAL, June 20, 1930

20-UNDERTAKER Henry W. Jenkins Sons

ADDRESS Orchard & Eutaw

Spec.—1-30—M. & T.—250 Blks

E 58124

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 58124

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Union Mem. Hosp. (ST.) 12-49 (WARD)

2-FULL NAME Richard Washington alexander.

(a) RESIDENCE NO. Inda annapolis (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of annie asquith

6 DATE OF BIRTH (month, day, and year) June 12, 1876.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
55 54		0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter engineer. 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Richard alexander.

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Julia Butler.

13 BIRTHPLACE OF MOTHER (city or town) W. Va.
(State or country)

14 Informant (Address) Chas. & Brother. Sassafras Md.

Filed JUN 19 1930 JAMES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1930. to June 19, 1930.

that I last saw h[illegible] alive on June 19, 1930.

and that death occurred, on the date stated above, at 12:38 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia, plus pulmonary emphysema.

(duration) yrs. mos 23 ds.

CONTRIBUTORY (Secondary) Pul. Hemorrhage [illegible]

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Lab & physical exam.

(Signed) Francis W. Slack, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR REMOVAL Charlestown W Va

DATE OF BURIAL June 20 1930

ADDRESS Baker [illegible]

20 UNDERTAKER Geo. W. Jenkins Sons Co.

Spec.—1-30—M. & T.—250 Bks

E 58125

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 58125

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hospital St. 15-61 WARD)

2-FULL NAME Dr Thomas Shew Worthington

(a) RESIDENCE NO. 3022 Garrison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kate Worthington

6 DATE OF BIRTH (month, day, and year) Oct. 19, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Playwright 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. Md (State or country)

PARENTS

10 NAME OF FATHER Thomas Shew Worthington

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Sousa Davis

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Hospital Records (Address)

15 Filed JUN 19 1930 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1930, to June 18, 1930, that I last saw him alive on June 18, 1930, and that death occurred, on the date stated above, at 10 20 P m. (Standard time)

The CAUSE OF DEATH* was as follows:

Bilateral Broncho-Pneumonia and Pleurisy

(duration) yrs. mos 10 da.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray

(Signed) Francis W. Gluck, M.D.

6/18, 1930 (Address) Union Memorial Gluck

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cem. DATE OF BURIAL June 21, 1930

UNDERTAKER Wm Tucker Sons ADDRESS North & Pa

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-902 ✓ E 58126

CERTIFICATE OF DEATH

REGISTERED NO. E 58126

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Home for Incurables ST. 43-52 WARD)

2—FULL NAME Mrs. Catherine E. Weber

(a) RESIDENCE NO. Home for Incurables ST. 40th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of John Weber

7 DATE OF BIRTH (month, day, and year) Dec. 9-1856

8 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	6	9	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

10 BIRTHPLACE (city or town) (State or country) Havre de Grace Maryland

PARENTS

10 NAME OF FATHER John A. Myers

11 BIRTHPLACE OF FATHER (city or town) Havre de Grace (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ann England

13 BIRTHPLACE OF MOTHER (city or town) Havre de Grace (State or country) Maryland

14 Informant Home for Incurables (Address) Mt. Prospect Ave. Balto.

Filed JUN 19 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to June 17, 1930, that I last saw her alive on June 17, 1930, and that death occurred, on the date stated above, at 8 30 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and hypertension over 5 yrs.

(duration)

CONTRIBUTORY (Secondary) Acute Cardiac 1/3 dy

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam —

(Signed) W. W. B. Mayo, M. D.

March 1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Havre de Grace, Md.

DATE OF BURIAL June 20 1930

UNDERTAKER J. J. Tuckerman & Sons

ADDRESS Havre de Grace

Spec.—2-29-28—L. F. S.—600 Bks.

E 58127 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58127

45

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Maryland General Hosp (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Howard & Madison ST., 15-6 WARD

2—FULL NAME Mrs Emma W Keiger

(a) RESIDENCE NO. 4112 Alto Rd. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 6 mos. 14 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis R. Keiger

7 DATE OF BIRTH (month, day, and year) Dec 5, 1852

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

10 NAME OF FATHER Robert Bumkhead

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Strider

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

PARENTS

14 Informant Hosp Record
(Address)

15 Filed ..... 19 HANSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17-1930

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1930, to June 17, 1930, that I last saw h alive on June 17, 1930 and that death occurred, on the date stated above, at 10:20 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Colon

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of June 10-1930

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) [illegible], M. D.

6/17, 1930 (Address) Md General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	June 1930

20 UNDERTAKER Wm J Medtner & Son ADDRESS North St

Spec.—1-30—M. & T.—250 Bks.

Gillespie ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

58128 E 58128

CERTIFICATE OF DEATH.

49

58128 George Gillespie

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Carlisle & Oliver ST., 9-17 WARD)

2-FULL NAME Geoge. Gillespie

(a) RESIDENCE NO. St Joseph's Hosp. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min
about	70	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly at

(b) General nature of industry, business, or establishment in which employed (or employer) St Joseph's Hosp.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) Regular Att. St Joseph's Hospital Mrs. Catherine Co

15 Filed ....., 19..... Registrar

C. HAMPSON JONES, M. D.

JUN 19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-19-30

17 I HEREBY CERTIFY, That I attended deceased from 5-29, 1930, to 6-19, 1930 that I last saw h[illegible] alive on 6-19, 1930 and that death occurred, on the date stated above, at 4.25 m.

The CAUSE OF DEATH* was as follows:

Squamous Cell Carcinoma Frontale

Advanced Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-Ray

(Signed) M B Hundley, M. D.

, 19 30 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL June 20 1930

20 UNDERTAKER Henry Hauck Sons Inc

ADDRESS 1301 E Eager St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 E 58129

REGISTERED NO.

E 58129

1-PLACE OF DEATH

City of Baltimore: (No. 42 E. York St. St., 27-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christian Fell.

(a) RESIDENCE NO. 42 E. York St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ---yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	60	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Do not know.
(b) General nature of industry, business, or establishment in which employed (or employer) 067
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

6/18, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Important. See instructions on back of certificate.

6/18/1930 C. HAMPSON JONES, M. D. Registrar

THE MORGUE 4715

UNIVERSITY OF MARYLAND

JUN. 8 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58130

E 58130

CERTIFICATE OF DEATH

2-4 182

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found floating off Davison Chemical Co. Curtis Bay

City of Baltimore: (No. ____ St. ____ Ward)

2-FULL NAME Rasmus Skjolingstab.

(a) RESIDENCE NO. 721 S. Broadway. St., ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State) Do not know.

Length of residenre in city or town where death occurred Do not know. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	21	------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mess boy, ofp
(b) General nature of industry, business, or establishment in whirh employed (or employer) Dredge Commander.
(c) Name of employer

9 BIRTHPLACE (city or town) Norway.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) ____
(State or rountry) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

15 Filed ____ 19 ____ C. HAMPSON JONES M.D. Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Found June 10, 1930

17 I HEREBY CERTIFY, That I took charge of the remains desrribed above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Occidental fall from a wharf.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ____

(duration) ....yrs. ....mos. ....ds.

18 Where was disease rontracted if not at plare of death? ____

Did an operation precede death? No. Date of ____

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, M. D.

6/18 1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Bureau of Vital Statistics

ADDRESS JUN 18 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58131

43 E 58131

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 Gough St. ST 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Krawczynski

(a) RESIDENCE NO. 1829 Gough St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) 1869

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Adam Krawczynski

(Address) 1829 Gough St.

15 Filed JUN 19 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1930

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1929, to June 18, 1930,

that I last saw h[illegible] alive on " " 19

and that death occurred, on the date stated above, at 12 50 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lower lip and neck

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 28 '29

Was there an autopsy? no

What test confirmed diagnosis? microscopic

(Signed) Chas. W. Mayer M. D.

, 19 (Address) 8 27 N. Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem June 21 1930

DATE OF BURIAL

20 UNDERTAKER John M Weber

ADDRESS 401 N Charles St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58132 — 31 E 58132

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2326 E. Oliver Street ST., 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret E. Tilghman

(a) RESIDENCE NO. 2326 E. Oliver Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard H. Tilghman

6 DATE OF BIRTH (month, day, and year) Oct. 24, 1882

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	7	23	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of indostry, bosiness, or establishment in which employed (or employer)

(c) Nsme of employer

8 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Philip Reinhardt

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Umbach

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Mr. Richard H. Tilghman

(Address) 2326 E. Oliver Street

15 Filed ....., 19 ..... Registrar

19 7530

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17th, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15th, 1929 to June 17th, 1930

that I last saw h.. alive on June 16th, 1930

and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 10 mos. — ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? X-ray - Sputum examination

(Signed) Otis C. Habliston, M. D.

, 19 (Address) 104 W. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemtery

DATE OF BURIAL 6-20- 1930

20 UNDERTAKER

ADDRESS 1606 N. CHESTER St.

G. HARRISON JONES, M. D.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58133

CERTIFICATE OF DEATH.

139 E 58133

REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) Wilkins & Caton Ave ST., 15-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lillian Tracey

(a) RESIDENCE No. 3000 Reisterstown Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David S. Tracey

6 DATE OF BIRTH (month, day, and year) Oct 6. 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone cut

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Denton Caroline Co Md

PARENTS

10 NAME OF FATHER Wm A Rue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Caroline Co Md

12 MAIDEN NAME OF MOTHER Sarah Calloway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Dr Guy Tracey (Address) 3000 Reisterstown Rd.

15 JUN 19 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUN 19 1930

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to June 19, 1930, that I last saw her alive on June 19 1930, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Uterine fibroid

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) embolus (Pulmonary)

(duration) ... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Druid Park apts

Did an operation precede death? yes Date of June 14-30

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy Exam

(Signed) J. T. Kyper, M. D.

, 19 (Address) 3321 Fredrick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL JUN 21 1930

20 UNDERTAKER Geo W Little ADDRESS 2705 EDMONDSON AVE.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58134 — CERTIFICATE OF DEATH. — 93 E 58134

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2216 Roslyn Ave. (St.) 15-61 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest A. Katzenberger

(a) RESIDENCE NO. 2216 Roslyn Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21st. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Business.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John A. Katzenberger

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary A. Bell.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Balto. Md.

14 Informant Louis A. Katzenberger,
(Address) 2216 Roslyn Ave.

15 9 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17th. 19 30

17 I HEREBY CERTIFY, That I attended deceased from July 24 1928 to June 17 1930, that I last saw him alive on June 17 1930, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Amyothrophic Lateral Sclerosis
(Spinal Cord)

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) ..... yrs. ..... mos. 2 Hrs ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [signature] M. D.

, 19 (Address) 3400 Walbrook Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery.

DATE OF BURIAL: June 20-30

UNDERTAKER: Chas. F. Krause Son

ADDRESS: 1810 Mt. Royal Ave.

Cor.—10-10-29—A Co.—100 Bks.

E 58135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 58135

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 422 East St. St. 5-8 Ward)

2-FULL NAME Imburgo Mary Cimino

(a) RESIDENCE NO. 422 East St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Santa Cimino

6 DATE OF BIRTH (month, day, and year) 1/16/1871

7 AGE	Years	Months	Days	IF LESS than 1 day, hrs. or min.
	59	4	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Basilio Imburgo

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Frank Cimino
(Address) 1842 N. Bond St.

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) June 19-30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Arrest Cont

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Riley, M. D.

June 19 30 (Address) 1639 Bruckes

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent Cem.

DATE OF BURIAL 6/20/30

20 UNDERTAKER George J. Pfeltz Inc

ADDRESS 1335 Bruckes

important. See instructions on back of certificate.

9 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58136

CERTIFICATE OF DEATH

185 E 58136

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1572 N Luzerne St. (Ward) 16-22

2-FULL NAME Thomas H. Leighman

(a) RESIDENCE NO. 1572 N. Luzerne St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 Color or Race: Wh

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie Leighman

6 DATE OF BIRTH (month, day, and year): Dec 25 1872

7 AGE: Years 57 | Months 6 | Days 4 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): School
(c) Name of employer: Md.

9 BIRTHPLACE (city or town): Md.
(State or country)

PARENTS

10 NAME OF FATHER: Ignatius Leighman

11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Carrie Perry

13 BIRTHPLACE OF MOTHER (city or town): Md.
(State or country)

14 Informant: Carrie Leighman
(Address): 1572 N Luzerne

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

JUN 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Accident.
Severe Contusions of Head, Back & Chest.
(duration) 1/2 hrs.
CONTRIBUTORY (Secondary) Fell through roof of School House
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ambulance to Mercy Hosp.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Hampson Jones, M. D.
June 16 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: June 18 1930

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1726 Eastland

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58137

CERTIFICATE OF DEATH

162

E 58137

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 649 Portland St. 12-30 Ward)

2-FULL NAME John Mazuravekas

(a) RESIDENCE NO. 649 Portland St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30 - 1930

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
		20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Mazuravekas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Veronka Sadavckas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Frank Mazuravekas
(Address) 649 Portland St.

15 [illegible] C. HAMPSON JONES, M. D. Registrar

JUN 20 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D.

6/20. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 20 1930
20 UNDERTAKER	ADDRESS
John Grebliunas	923 E. Pratt St.

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58138

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58138

CERTIFICATE OF DEATH.

REGISTERED NO. 15-167

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3623 (ST.) Springdale Ave (WARD)

2-FULL NAME Helen Chase Monlell

(a) RESIDENCE NO. 3623 (ST.) Springdale Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? 81 yrs. 4 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin Ellsworth Monlell

6 DATE OF BIRTH (month, day, and year) Feby 13/1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Ellen A Chapman

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) Conn.

12 MAIDEN NAME OF MOTHER Mary E Chase

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Mrs May Monlell (daughter)

(Address) 3623 Springdale Ave

15 Filed JUN 20 1930 19 C. HERBERT JONES, M. D. Registrar

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from April 3rd, 1930, to June 18th 1930, that I last saw her alive on June 18th, 1930, and that death occurred, on the date stated above, at 5 pm m.

The CAUSE OF DEATH* was as follows:

Metastases of Carcinoma of Breast to Pelvic bone - Senility -

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

Cachexia (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M P Byerly, M. D.

June 17th 1930 (Address) 3046 North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. — DATE OF BURIAL June 21, 30

20 UNDERTAKER Stewart Monk Co — ADDRESS Balto.

Spec.—1-30—M. & T.—250 Blks.

2B 8583139 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58139

Pet.

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2-FULL NAME Marian Colditz

(a) RESIDENCE NO. Colgate - Md ST.... WARD....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. Born mos. 10 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

6a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7-2-29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11.	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — (b)
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS
10 NAME OF FATHER Lyman Colditz
11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia
12 MAIDEN NAME OF MOTHER Corene Johnson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Parent
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 6-20 1930 C. HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-19-30

17 I HEREBY CERTIFY, That I attended deceased from 6-17-, 1930, to 6-19-, 1930,
that I last saw h[illegible] alive on 6-19-, 1930,
and that death occurred, on the date stated above, at 11[45]6 m.

The CAUSE OF DEATH* was as follows:
Whooping Cough
Whooping Cough Encephalitis

(duration) ....yrs. ....mos. 10 ds.
CONTRIBUTORY (Secondary) Pneumonia (duration) ....yrs. ....mos. 3 ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J W Buckford, M. D.
6/19 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Madamond. DATE OF BURIAL June 24 1930

20 UNDERTAKER John F Denny ADDRESS 715 Eastern Ave

r.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 58140

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 58740

1-PLACE OF DEATH

City of Baltimore: (No. 1506 E. Hoffman St., St., 8-17 Ward)

2-FULL NAME Herbert L. Hoffma Levy

(a) RESIDENCE NO. 1506 E. Hoffman St., St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lena Levy

6 DATE OF BIRTH (month, day, and year)
June 11th- 1889

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	41 61	0	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Confectioner 019
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Poland

14 Informant Lena Levy
(Address) 1506 E. Hoffman

Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

N 20 1930 [signature]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19th-30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage- Aortic Aneurysm
(Rupture)

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Hospitory-Dr. Kadrer

(Signed) [signature] M. D.

6/19/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 6-20 1930

20 UNDERTAKER Jack Lewis, 1434 E Balto

ADDRESS

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 58141 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 J E 58141

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 15-21 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Rosenberg

(a) RESIDENCE NO. 1728 N. Monroe St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Rebecca Rosenberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Yehuda Rosenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Yetta —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Rebecca Rosenberg

(Address) 1728 N. Monroe St.

15 Filed JUN 20 1930 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1930, to June 19, 1930, that I last saw h/his alive on June 19, 1930, and that death occurred, on the date stated above, at 3 45 P m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Partial - Yes

What test confirmed diagnosis Clinical Observation

(Signed) Meeton B Kirsh, M. D.

6/20 1930 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Hebrew Rosedale

DATE OF BURIAL 6-20-1930

20 UNDERTAKER Jack Lewis, 1431 E. Baltimore St.

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

E 58142 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓

139 E 58142

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) Wilkins Ave. ST. 70-9 WARD)

2-FULL NAME Trisanna Riley

(a) RESIDENCE NO. 168 Cabutan Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 11th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	60 Yrs	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 17°

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Michael J. Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr D. Riley.

(Address) 168 Cabutan Rd

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 5th 1930 to June 19 1930

that I last saw h e alive on June 18 1930

and that death occurred, on the date stated above, at 9 15 a. m. Standard time

The CAUSE OF DEATH* was as follows:

Followed Operation for fibroid Tumor of uterus

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolism Pulmonary

15 hours (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of June 16-1930

Was there an autopsy? Partial

What test confirmed diagnosis? by Exclusion

(Signed) J. Thos B. Deegan M. D.

19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL June 21 1930

20 UNDERTAKER John J. Cowan & Son ADDRESS 901 Hollins St.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58143

E 58143

CERTIFICATE OF DEATH.

REGISTERED NO. 24001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 N. Montford Ave ST.) 6-16 (WARD)

2-FULL NAME Magdelena Miller

(a) RESIDENCE NO. 1409 N. Montford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of F. Frank Miller

6 DATE OF BIRTH (month, day, and year) July 7 72

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Sicklinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant F. Frank Miller

(Address) 1409 N. Montford Ave

15 Filed JUN 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) June 18 30

17 I HEREBY CERTIFY, That I attended deceased from June 2 1930, to June 18 1930,

that I last saw h alive on June 17 1930,

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Arteritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Williams, M. D.

, 19 (Address) 340 S Shore Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL 6/21 1930

20 UNDERTAKER Philip Hennig 2016

ADDRESS Oldham St

Cor.—10-10-29—A Co.—100 Bks.

Oscar F Rhodes

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58144

CERTIFICATE OF DEATH

90 E 58144

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

Pronounced dead at Emery Hospital

City of Baltimore: (No. 2 W Rhodes St. 11-24 Ward)

2-FULL NAME Oscar W. Rhodes

(a) RESIDENCE NO. Alvin Apts St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5a yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Annie Francis

6 DATE OF BIRTH (month, day, and year) May 24 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	74		2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER S. Rhodes

11 BIRTHPLACE OF FATHER (city or town) Va Va
(State or country)

12 MAIDEN NAME OF MOTHER V. Ward

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. Va

14 Informant O. F Rhodes
(Address) Alvin Apts

15 Filed JUN 20 1930 H. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. Dis Cardi

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. T. Ruby, M. D.

June 20, 1930 (Address) 609 Barr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	6/21 1930
20 UNDERTAKER Wm Cook	ADDRESS 1217 N Paul St

Spec.—1-30—M. & T.—250 Bks.

E 58145 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58145

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 McCulloh ST 1124 WARD)

2-FULL NAME Rachel C Williams

(a) RESIDENCE NO. 1124 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C	W.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Williams

7 DATE OF BIRTH (month, day, and year) May 17th 1851

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	1		

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) Balto Co. (State or country) Md

PARENTS

10 NAME OF FATHER Tobias Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nora V. Cornish

(Address) 1124 McCulloh St

15 FILED 2 0 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17-30

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to June 17, 1930, that I last saw h alive on June 15-, 1930, and that death occurred, on the date stated above, at 10 09 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Infant (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Debilitation of heart

2 wks (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

6 A 1930 (Address) 1612 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Crm

DATE OF BURIAL 6-20 1930

UNDERTAKER Byron Wright ADDRESS 1218 N Gay St

Spec.—1-30—M. & T.—250 Bks.

E 58146 E 58146

HEALTH DEPARTMENT—CITY OF BALTIMORE

153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 27-42 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Minnie Albrecht

(a) RESIDENCE No. 6121 Everall Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Peter Albrecht

6 DATE OF BIRTH (month, day, and year) Dec. 2, 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
66	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Carl Hirschfeldt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Peter Albrecht Jr

(Address) 6121 Everall Ave.

15 JUN 20 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17-1930

17 I HEREBY CERTIFY, That I attended deceased from June 11-, 1930, to June 17, 1930, that I last saw her alive on June 17-, 1930, and that death occurred, on the date stated above, at 12:05 P m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Left Leg

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Pneumonia hypostatic

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of June 12-1930 (Incision & drainage of Leg)

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs & symptoms

(Signed) Carl F. Imbach M. D.

6/17, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL 6/20 1930

20 UNDERTAKER Henry H. Mitzke, 4101 E Monument Ave.

ADDRESS

pec.—1-30—M. & T.—250 Bks

E 58147

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58147

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST., 161 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME William J. Kavanaugh

(a) RESIDENCE NO. 3117 Dillon ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Unknown~~ Charlotte Katherine Donnelly.

6 DATE OF BIRTH (month, day, and year) April 27, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Unknown~~ Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boston

(State or country) Mass.

PARENTS

10 NAME OF FATHER James Kavanaugh

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country) ~~Unknown~~

12 MAIDEN NAME OF MOTHER ~~Unknown~~ Della Bracken

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country) ~~Unknown~~

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed JUN 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-18-30

17 I HEREBY CERTIFY, That I attended deceased from 5-29-30, 19..., to 6-18-30, 19...,

that I last saw him alive on 6-18-30, 19...,

and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Alcoholism, chronic & acute

Korsakow's Syndrome over 2 yrs. da.

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Myocarditis, chronic over 20 da.

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thomas H. McLean, M. D.

6-19, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

UNDERTAKER Lilly & Gaither Inc.

DATE OF BURIAL June 21 1930

ADDRESS 408 S. Howard St

Spec.—1-12-23—M&T—500 Blks.

E 58148 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58148

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 334 (ST.) Fleet (WARD) 26-2

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Fiedler

(a) RESIDENCE NO. 3311 (ST.) Fleet (WARD) 26
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	Wht	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18, 30

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2	24 hrs.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — No
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Peter Fiedler

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Boettcher

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Peter Fiedler
(Address) 3311 Fleet St.

15 Date Received NOV 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1930

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1930 to June 19, 1930
that I last saw him alive on June 19, 1930
and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Acute Anemia

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) William H. Sauer M. D.

(Address) 801 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem — DATE OF BURIAL June 20 1930

21 UNDERTAKER D. Lilly & Sons — ADDRESS 4538 Wabash Ave

Spec.—1-30—M. & T.—200 Blks

E 58149

E 58149

90 E 58149

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 17-24 WARD)

2-FULL NAME Olivia Miller

(a) RESIDENCE NO. 1112 Shields Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec. 25 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Saulisbury

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Fosett

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Jane ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

Informant Records of

(Address) Balto. City Hosp.

15 Filed 6-20 1930 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-17-30

17 I HEREBY CERTIFY, That I attended deceased from 6-13-30, 19..., to 6-17-30, 19...,

that I last saw her alive on 6-17-30, 19...,

and that death occurred, on the date stated above, at 7:30 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) more than yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical exam

(Signed) Paul Podgal, M. D.

6-18, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 6-20 1930

20 UNDERTAKER Paul Easton

ADDRESS 756 Dean

Spec.—1-30—M. & T.—250 Bks

E 58150 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58150

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) S. 15-21 (WARD)

2-FULL NAME Rose E. Morrison

(a) RESIDENCE NO. 1900 N. Payson St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widow

5a If married, widowed, or divorced (or) WIFE of Arthur W. Morrison

6 DATE OF BIRTH (month, day, and year) Oct 13 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6 2 yrs.	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Hugo Goertz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Sheetz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

Informant Jos. A. Morrison

(Address) 1900 N. Payson St Pa

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/19/30

17

I HEREBY CERTIFY, That I attended deceased from 6/13/30, 19..., to 6/19/30, 19...,

that I last saw h. alive on 6/19/30, 19...,

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes No Date of 6/13/30

Was there an autopsy?

What test confirmed diagnosis? Microscopic

(Signed) David Tenner, M. D.

6/19, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Thomas Cem Md

DATE OF BURIAL June 21 1930

UNDERTAKER Geo A Farley

ADDRESS 1800 N Fayette

JUN 20 1930 C. HAMPSON JONES, M.D.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58151

E 58151

129

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp (S.) 16-23 (WARD)

2-FULL NAME John F. Barnes

(a) RESIDENCE NO. 806 Harlem Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Widowed ~~Married~~

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Georgia Barnes

6 DATE OF BIRTH (month, day, and year) Feb. 13 - 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER George Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Betty Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Bernice Chew

(Address) 806 Harlem Ave

15 Filed JUN 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from 5/18, 1930, to 6/18, 1930, that I last saw h[illegible] alive on 6/18, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypertrophied Prostate

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of 5/18/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) B Barnes, M. D.

6/18, 1930 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 6-21-1930

20 UNDERTAKER Sam'l H. Chase & Son

ADDRESS 1400 Mosher

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58152

E 58152

CERTIFICATE OF DEATH.

REGISTERED NO. 28-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3612 Plateau Ave ST. ..... WARD)

2-FULL NAME Ida Virginia Rutter

(a) RESIDENCE NO. 3612 Plateau Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H. Rutter

6 DATE OF BIRTH (month, day, and year): Oct. 10, 1859

7 AGE: Years 70 | Months 8 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Samuel Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Julia Mott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mr. John H. Rutter Sr.
(Address) 3612 Plateau Ave.

15 Filed JUN 20 1930 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1930, to June 18, 1930, that I last saw alive on June 17, 1930, and that death occurred, on the date stated above, at 6.15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? X Ray.

(Signed) A. C. Smith, M. D.

1930 (Address) 4509 Gatewood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — DATE OF BURIAL: June 18 1930

20 UNDERTAKER: Thos. J. McKenrow Sons — ADDRESS: Forest Ave

Spec.—2-29-28—L. F. S.—500 Bks.

Barber ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

32 E 58153

CERTIFICATE OF DEATH

E 58153

REGISTERED NO. 27 30

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dorothy Barber

(a) RESIDENCE NO. 510 W. Lee St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	15	14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Barber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bessie Wilkes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant Bessie Barber

(Address) 510 W. Lee St. Balto, Md.

15 Filed JUN 20 1930 19 HAMILTON JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to June 18, 1930, that I last saw her alive on June 18, 1930 and that death occurred, on the date stated above, at 6 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebro spinal Meningitis

(Tuberculous)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lumber puncture

(Signed) Myron G. Lee, M. D.

6/19. 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn cemetery

DATE OF BURIAL June 19 30

20 UNDERTAKER Mrs. P. G. Elliott

ADDRESS 1725 Ashland Ave

Spec.—1-10-21—M.&T.—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58154

CERTIFICATE OF DEATH.

47

E 58154

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1310 W. Lombard St. ST. 19-24 WARD)

2-FULL NAME Grace L. Adkins

(a) RESIDENCE NO. 1310 W. Lombard St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Archibald Adkins

6 DATE OF BIRTH (month, day, and year) March 8, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Lawrence Corbett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Philomena Dalton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Miss Grace L. Adkins

(Address) 1310 W. Lombard Street

15 Filed JUN 20 1930 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1930.

17 I HEREBY CERTIFY, That I attended deceased from April 2 1920. to June 18 1920.

that I last saw her alive on June 18 1930.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of April 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar E. Tracy M. D.

, 19 (Address) 500 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL June 23 1930

UNDERTAKER Edgar E. Tracy & Son

ADDRESS 118 W. Mt Royal ave

Spec.—1-30—M. & T.—250 Bks.

E 58155 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 44 E 58155

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 N. Mount Ave ST., 28-6 WARD)

2-FULL NAME Leo Heinmiller.

(a) RESIDENCE NO. 1501 N. Mount Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mrs. Lilly C. Heinmiller

6 DATE OF BIRTH (month, day, and year) Feb 6th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	5	15	

8 OCCUPATION OF DECEASED retired

(a) Trade, profession or particular kind of work Carriage Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 007

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Paul Heinmiller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Sophia

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Miss Mary Heinmiller
(Address) 1501 Mount Ave

20 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 8th, 1930, to June 30th, 1930, that I last saw him alive on June 30th, 1930, and that death occurred, on the date stated above, at 10 45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical exam

(Signed) W. R. Lucas, M. D.

6/30, 1930 (Address) 324 N Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cem — DATE OF BURIAL 6-24 1930

20 UNDERTAKER William Cook — ADDRESS 1217 W Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

58156

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58156

CERTIFICATE OF DEATH

45

REGISTERED NO. 15-21

1—PLACE OF DEATH Maryland General Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2—FULL NAME Mrs Caroline Palmer

(a) RESIDENCE NO. 2021 W. North Ave ST., ... WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H Palmer

6b DATE OF BIRTH (month, day, and year) Feb 15 - 46

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Monyeund

PARENTS

10 NAME OF FATHER Otho Wachtel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Power

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hosp Record

(Address) .....

Filed JUN 20 1930 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19-1930

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1930, to June 19 1930

that I last saw h.er alive on June 19, 1930

and that death occurred, on the date stated above, at 10 45 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) ? yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 6/19/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H E Kerpschneider, M. D.

6/17, 1930 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greencastle Pa.

DATE OF BURIAL June 4 1930

20 UNDERTAKER W M Routson

ADDRESS 223 E N Mts

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 58157

E 58157

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 126 N. Streper ST., 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Salomon

(a) RESIDENCE NO. 126 N. Streper ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced (or) WIFE of Peter Salomon

6 DATE OF BIRTH (month, day, and year) Feb. 13 1854

7 AGE Years 76 Months 4 Days 6 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Lohner

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant Philip Salomon (Address) 126 N. Streper st

15 Filed JUN 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1930

17 I HEREBY CERTIFY, that I attended deceased from June 5 1930, to June 19 1930, that I last saw h alive on June 18 1930 and that death occurred, on the date stated above, at 11-15 a m

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustav C. Thearle M. D.

6/19 1930 (Address) 16 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem

DATE OF BURIAL June 21 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

Spec.—1-30—M. & T.—250 Blks

E 58158

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58158

125

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 73-31 STREET) (WARD)

2-FULL NAME Annie L. Taylor

(a) RESIDENCE NO. 1426 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) R. I.

PARENTS

10 NAME OF FATHER Edw. Sprangna

11 BIRTHPLACE OF FATHER (city or town) (State or country) R. I.

12 MAIDEN NAME OF MOTHER Mary Duffy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) R. I.

14 Informant Records of (Address) Balto. City Hosp.

Filed JUN 20 1930 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-19-30

17 I HEREBY CERTIFY, That I attended deceased from 6-26-28, 19..., to 6-19-30, 19..., that I last saw her alive on 6-19-30, 19..., and that death occurred, on the date stated above, at 9:56 m.

The CAUSE OF DEATH* was as follows:

Abscess of Pancreas

(duration) UNKNOWN. yrs. mos. ds.

CONTRIBUTORY (Secondary) Cholecystitis and Cholangitis (duration) UNKNOWN. yrs. mos. ds.

18 Where was disease contracted if not at place of death? UNKNOWN.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padget, M. D.

6-20, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 6/21 1930

UNDERTAKER Philip Herring ADDRESS 2016 Orleans

Spec.—1-30—M. & T.—250 Blks

58159 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58159

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hos ST. 3448 WARD) 49

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Malcolm B Thompson

(a) RESIDENCE NO. 3965 Welsby Ave., Govans, Maryland ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Jones Thompson

6 DATE OF BIRTH (month, day, and year) 2-27-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer) f&b

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Emily Gibbons

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records (Address)

15 Filed 6-20-1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 19, 19, that I last saw him alive on , 19, and that death occurred, on the date stated above, at 7 10 P. m. Daylight Saving

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Brain Tumor

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 6-18-30

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) R R Chamberlaine, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	June 23 19 30
20 UNDERTAKER	ADDRESS
Ind. Wm. Funeral Home	Pine Ellicott

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 58160

E 58160

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp ST. 17-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie E. Cathcart

(a) RESIDENCE NO. 38 W 25th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 2 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 25, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Charles Cathcart

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Meyer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Hosp Record
(Address)

15 Filed JUN 20 1930, 19 Registrar C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to June 19, 1930,
that I last saw h[illegible] alive on June 19, 1930
and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Left Breast

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Mar, 1930
No

Was there an autopsy?

What test confirmed diagnosis? Clinical + Laboratory

(Signed) H. E. Reifschneider, M. D.

6/19, 1930 (Address) md General Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount

DATE OF BURIAL June 21 1930

20 UNDERTAKER Chas. Mitchell Sons

ADDRESS [illegible]

Spec.—1-30—M. & T.—250 Bks.

58161

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 58161

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B. 15-59) REGISTERED NO.

CITY OF BALTIMORE: (NO. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard James

(a) RESIDENCE NO. 1512 N. Fremont ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Jamaica

PARENTS

10 NAME OF FATHER William James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica

12 MAIDEN NAME OF MOTHER Ann Rebecca ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica

14 Informant Hospital Records (Address) UNIVERSITY OF MARYLAND

15 JUN 20 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1930, to June 18, 1930, that I last saw him alive on June 18, 1930, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

6-18, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL JUN 20 1930

ADDRESS

1-30—M. & T.—100 B—50L

E 58162

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 58162

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 N. Eden St ST., 5-8 WARD)

2-FULL NAME Mary Wardlow

(a) RESIDENCE NO 318 N. Eden St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1830

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic 870
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mercersburg, Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Alice Felman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sarah E. Felman
(Address) 1220 N. Spring St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardio-Renal Disease

Found dead in Bed

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Hamman, M. D.
Coroner

6/19/30 (Address) 500 E north ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mercersburg, Pa

DATE OF BURIAL June 21 1930

20 UNDERTAKER Milton Davis

ADDRESS 413 N Eden St.

Spec.—2-29-28—L. F. S.—500 Bks.

(Proctor)

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 58163

CERTIFICATE OF DEATH

E 58163

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2009 Borden ~~Bordew~~ ST. 6-10 WARD)

2—FULL NAME Fannie Sweten

(a) RESIDENCE NO. 2009 Borden ~~St.~~ ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6 If married, widowed or divorced HUSBAND of (or) WIFE of Daniel Sweten

7 DATE OF BIRTH (month, day, and year) May 2 1869

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Henry Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maine Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Maine Davis

(Address) [illegible]

15 Filed JUN 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18-30

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1930 to June 18, 1930,

that I last saw h alive on June 18, 1930

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchio Pneumonia

Primary

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. L. Allen, M. D.

June 19 1930 (Address) 38 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arbry County. June 22 1930

20 UNDERTAKER William Davis ADDRESS 1320 Eckert

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58164 E 58164

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto. City Hosptals

CITY OF BALTIMORE: (NO. 45-54 WARD)

2-FULL NAME Walter Gibson

(a) RESIDENCE NO. 1727 N. Carey St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) July 25, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
51 52		10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joe Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 6-20 1930, 19 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16-30

17 I HEREBY CERTIFY, That I attended deceased from 6-20-29, 19..., to 6-16-30, 19..., that I last saw him alive on 6-16-30, 19..., and that death occurred, on the date stated above, at 4:40 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic, without oedema.

morethon 1 yrs. mos ds.
(duration)

CONTRIBUTORY (Secondary) Hypertension UNKNOWN.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

6-17, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19 JUN 20 1930

20 UNDERTAKER

ADDRESS

Commissioner of Health

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58165

CERTIFICATE OF DEATH.

89 E, 58165

REGISTERED NO.

1-PLACE OF DEATH Gallows Monument St tour dist

City of BALTIMORE: (No. ~~Morey Hospital~~ St. 11-15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Shipley

(a) RESIDENCE NO. 607 E. Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Shipley

6 DATE OF BIRTH (month, day, and year) Apr. 16, 1868

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min.
	62	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R.R. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Pennsylvania R.R.

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Richard Shipley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Richard M. Shipley

(Address) Forndale, Md.

CHARLES JONES M D

Registrar

0 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(Duration) yrs. mos. Sudden

CONTRIBUTORY (Secondary) Hardening of arteries

(Duration) yrs. mos. ds.

(Signed) C. T. Reilly M. D.

(Coroner)

June 20, 1930 (Address) 1639 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial June 23 1930

20 UNDERTAKER John F. Denny ADDRESS 215 Lis[illegible] St

very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 258166

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58166

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 26-37 WARD)

2-FULL NAME Daniel White or Walkonew

(a) RESIDENCE NO. 646 S 14th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of ~~Unknown~~ Mary White

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Rolling Mill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Finland

PARENTS

10 NAME OF FATHER Ernest White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Finland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Friend (Address) JOHNS HOPKINS HOSPITAL

15 Filed 20 1930 19 Reg. ACH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20-1930

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to June 20, 1930, that I last saw him alive on June 20, 1930, and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Tbc peritonitis and pulmonary Tbc

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Perforation Tbc ileum small intestine (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 15th 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) George B. Finney M. D.

6/20/30 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL June 22 1930

UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore St & Broadway

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58167

74-E 58167

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sieling Sanitarium

CITY OF BALTIMORE: (No.) 800 Chapelgate Lane ST. 7-12 WARD)

2-FULL NAME JOHN HENRY DAVIS

(a) RESIDENCE NO. 824 N. Kenwood Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Davis

6 DATE OF BIRTH (month, day, and year) March 21, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 7 Years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Wm. H. Davis (Son)
(Address) 824 N. Kenwood Ave.

15 Filed JUN 20 1930 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1930

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to June 18, 1930, that I last saw him alive on June 18, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage (apoplexy)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A. H. Fleming, M. D.

6/18, 1930 (Address) Catonsville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Paul's Cemetery — DATE OF BURIAL: June 21, 1930

20 UNDERTAKER: Henry Sander & Sons, Inc. — ADDRESS: Baltimore & Broadway.

TION is very important. See instructions on back of Certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 58168

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 58168

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 North Bradford ST., 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph G Winkler

(a) RESIDENCE NO. 824 N. Bradford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Veronicia Winkler

6 DATE OF BIRTH (month, day, and year): Mar 21. 1860

7 AGE — Years: 70 — Months: 3 — Days: 29 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Not Know

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Not Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Veronicca Winkler

(Address): 824 N. Bradford St.

Filed 2 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 19 30 to June 20 19 30

that I last saw him alive on June 19 30

and that death occurred on the date stated above, at 7 00 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs.

CONTRIBUTORY (Secondary) Arteriosclerotic Cardiac Relatety

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

(Address)

*State the Disease Causing Death. In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ark Hill Cemetery — DATE OF BURIAL: June 22 1930

20 UNDERTAKER: August Pasek 2406 — ADDRESS: Ashland ave.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58169 24 E 58169

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL ST. 10-13 WARD)

2-FULL NAME Lota Taylor

(a) RESIDENCE NO. 1426 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	child

(a) If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-25-30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Std

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Ottie Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Friend

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 6-17 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-19-30

17 I HEREBY CERTIFY, That I attended deceased from 5-26-, 1930, to 6-19, 1930, that I last saw h[er] alive on 6-19, 1930, and that death occurred, on the date stated above, at 10:20 a. m.

The CAUSE OF DEATH* was as follows:

Meningococcus Meningitis

(duration) yrs. mos 3 weeks ds.

CONTRIBUTORY (Secondary) B. coli infection

(duration) yrs. mos. 3 days ds.

18 Where was disease contracted if not at place of death? 1426 E. Chase St

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bacteriological

(Signed) J W Bickford, M. D.

6/17 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL June 21st 1930

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1705 Eastern Ave

Spec.—1-12-23—M&T—500 Blks.

E 58170

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58170

CERTIFICATE OF DEATH.

38

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 Madison St. WARD) 14-20

2-FULL NAME Daisy Harrison

(a) RESIDENCE NO. 2020 Madison St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July - 1893

7 AGE 36 Years 37 Months 11 Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lindig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Fletcher Bryan
(Address) New York City

15 6-21 1930

16 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/14 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/2 1930, to 6/14, 1930, that I last saw h[illegible] alive on 6/14, 1930 and that death occurred, on the date stated above, at 6 P m

The CAUSE OF DEATH* was as follows:

Aortic thrombosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

6/21, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Cemetery

DATE OF BURIAL June 21 1930

20 UNDERTAKER Samuel I. Kunstler

ADDRESS Middle

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58171

E 58171

CERTIFICATE OF DEATH.

REGISTERED NO. 46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 54 WARD)

2-FULL NAME Florence Fowlkes

(a) RESIDENCE No. 1419 Orleans ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Langston

6 DATE OF BIRTH (month, day, and year) 3-20-1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Sabina Marshal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Nellie?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Record (Address)

Filed 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16-30

17 I HEREBY CERTIFY, That I attended deceased from 3-29, 1930, to 6-16, 1930, that I last saw h[illegible] alive on 6-16, 1930, and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma uterus

(duration) Unknown mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

6-18, 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green V.a — DATE OF BURIAL June 4, 30

20 UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans st

Spec.—1-30—M. & T.—250 Bks.

E 58172 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58172

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 Baker St. ST. 15-21 WARD)

2-FULL NAME Brosis Rabinowitz

(a) RESIDENCE NO. 1701 Baker St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Joseph Rabinowitz

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lewis Bale

(Address) 1739 Bale St

Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20-30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27-, 19 29, to June 20, 19 30,

that I last saw h alive on June 20, 19 30,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

about (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical exam.

(Signed) Nathan F. Smith, M. D.

19 (Address) 2318 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Helen Wash. Road

DATE OF BURIAL 6-22-1930

ADDRESS

20 UNDERTAKER Jack Lewis, 1439 Bale

2 1 1930

Registrar

Spec.—1-30—M. & T.—250 Blks. 11

E 58173 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58173

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3208 INGLESIDE ST. 27-55 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benj Aitken

(a) RESIDENCE No. 3208 Inglenide ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Rebecca Aiken

6 DATE OF BIRTH (month, day, and year) March 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Benj Aitken

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Rebecca Aitken

(Address) 3208 Inglenide ave

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20-30

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1930 to June 19, 1930

that I last saw h... alive on June 19, 1930

and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary TBC

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary edema, cardiac failure

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Nathan Jolliffe, M. D.

, 1930 Address) 1750 Bloom

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodmen Circle Cem

DATE OF BURIAL 6/22 1930

20 UNDERTAKER Jack Lewis 1439 E Balto St

ADDRESS

Spec.—1-30—M. & T.—250 Blks.

E 58174

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 58174

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1634 Ruxton ave ST. 15-68 WARD)

2-FULL NAME Katie Wasserstrug

(a) RESIDENCE No. 1634 Ruxton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Sing C

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): unk

7 AGE: Years 38; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt Md

PARENTS

10 NAME OF FATHER Jacob Wasserstrug

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Ida Katz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Ida Wasserstrug

(Address) 1634 Ruxton Ave

15 Filed 2 1 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/19/1930

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1930, to June 19, 1930, that I last saw her alive on June 12, 1930, and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos da.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Ex

(Signed) J. M. Lampkin, M. D.

6/19 1930 (Address) 3409 Callaway av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Rd

DATE OF BURIAL: 6/22 1930

20 UNDERTAKER: Jack Levin

ADDRESS: 1439 E Balto St

Spec.—1-30—M. & T.—250 Blks.

E 58175 HEALTH DEPARTMENT—CITY OF BALTIMORE 57 E 58175

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Monument ST. 20-29 WARD)

2-FULL NAME Maggie Muenzing

(a) RESIDENCE NO. 309 Fremont St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE white | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of John Muenzing

6 DATE OF BIRTH (month, day, and year) Sept 17-1871

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Seibrandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Muenzing

(Address) 309 Fremont St

Filed JUN 21 1930, 19 Registrar

C. HAMPSON GORE, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to June 19, 1930, that I last saw her alive on June 19, 1930, and that death occurred, on the date stated above, at 5.40 p.m.

The CAUSE OF DEATH* was as follows:

diabetic coma (2 hrs)

diabetes mellitus

sinks (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) diabetic gangrene (duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) Jacob H. Conn, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL June 21, 1930

UNDERTAKER L. O. Wagner ADDRESS 150 N. Bradford

Spec.—1-30—M. & T.—250 Blks.

Issuing of burial extended to June 24/30
J. Frederick Stanford Asst Com

E 58176 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58176

31

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 18 2b

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Manighan

(a) RESIDENCE NO. 794 W. Mulberry st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Manighan

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Clay Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Mary Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records (Address)

15 Filed JUN 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to June 15, 1930, that I last saw her alive on June 15, 1930, and that death occurred, on the date stated above, at 1.50 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

6-15, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Spartanburg, S. C.

DATE OF BURIAL June 24, 1930

20 UNDERTAKER Mrs Katie R Williams

ADDRESS 322 1/2 Schroeder St

1-30—M. & T.—100 B—50L

E 58177

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58177

CERTIFICATE OF DEATH

129

8-16

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1332 N. Eden ST. (WARD)

2-FULL NAME Alice V. Meyers

(a) RESIDENCE NO 1900 N. Collington ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edward J. Meyers

6 DATE OF BIRTH (month, day, and year) Jan 17/1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	5	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Hagerstown
(State or country) Md

PARENTS

10 NAME OF FATHER John A. Glass

11 BIRTHPLACE OF FATHER (city or town) Penna
(State or country)

12 MAIDEN NAME OF MOTHER Mary Emmert

13 BIRTHPLACE OF MOTHER (city or town) Boonsboro, Md.
(State or country)

14 Informant Mary Glass (mother)
(Address) 1900 N. Collington Ave

15 Filed ....., 192 ..... Registrar

6/21/30

C. H. PERSON, Jones, M. D.

JUN 21 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Chr myocarditis & Nephritis

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Chr Alcoholism

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) [signature] M. D.
Coroner

(Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rose hill Cemetery, Hagerstown Md.	June 23 1930

20 UNDERTAKER George M. Zinkan

ADDRESS 1737 E. Eager

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58178

CERTIFICATE OF DEATH

20 E 58178

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Church Mercy Hosp St. 21-24 Ward)

2-FULL NAME Mrs. M. Breed

(a) RESIDENCE NO. 1210 Glyndon ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Mah	white	Marr'd

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Pauline M. Breed

6 DATE OF BIRTH (month, day, and year) April 19-1876

7 AGE	Years	Mont's	Days	IF LESS than I day hrs. or min.
	3-4	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Bartell Hayward & Co
(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.
(State or country)

PARENTS

10 NAME OF FATHER F. Breed

11 BIRTHPLACE OF FATHER (city or town) Fauquier
(State or country)

12 MAIDEN NAME OF MOTHER Frances Butler

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant P. Breed
(Address) 1210 Glyndon

15 Filed 21 1930 19 C. HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20-30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Prob. Fract. Skull - Injured Lung Both Caused by being accidentally struck by a jitney driven by Bartell Hayward. S. McHenry St

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no. S. McHenry St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. J. Riley, M. D.

June 21. 1930 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 6/23 1930

20 UNDERTAKER William Cook — ADDRESS 1275 Fulton

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58179

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58179

CERTIFICATE OF DEATH.

3 1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2499 (St.) Druid Hill Ave (Ward) 18-59

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Verlie Reeder

(a) RESIDENCE NO. 2499 (St.) Druid Hill Ave (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 31, 1907

7 AGE — Years: 23 — Months: 4 6 — Days: 15 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0/10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Douglas Reeder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Blanche Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Blanche Brooks

(Address) 2499 Druid Hill Ave

15 Filed 2 1 1930 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18/30 1.20 P.M.

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929, to June 18, 1930,

that I last saw her alive on June 18, 1930,

and that death occurred, on the date stated above, at 1:20 a. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No What test confirmed diagnosis? Sputum Test

(Signed) W. S. Taylor, M. D.

, 19 (Address) 1522 Harlem Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: June 21, 1930

20 UNDERTAKER: Mrs R. G. Elliott — ADDRESS: 715 Ashland Ave

Spec.—1-12-23—M&T—500 Rls.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58130

CERTIFICATE OF DEATH.

117 E 58130

1-PLACE OF DEATH West Balto Gen Hosp. REGISTERED NO.....

CITY OF BALTIMORE: (No.) Balto, Md ST., 19-28 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Puskett

(a) RESIDENCE NO. 1519 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24, 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
16	17	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

009

9 BIRTHPLACE (city or town) (State or country) Carroll Co; Md

PARENTS

10 NAME OF FATHER Wm A Puskett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co; Md

12 MAIDEN NAME OF MOTHER Mrs Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co, Md

14 Informant Mrs Wm Puskett (Address) 1519 McHenry

15 Filed JUN 22 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/20 1930

17

I HEREBY CERTIFY, That I attended deceased from June 19, 1930, to June 20, 1930, that I last saw h alive on June 20, 1930, and that death occurred, on the date stated above, at 4.05 P m.

The CAUSE OF DEATH* was as follows:

~~Peritonitis~~

Ruptured Appendix

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) ~~Ruptured Appendix~~ Peritonitis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1519 McHenry St

Did an operation precede death? Yes Date of 6-19-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) S. A. Alessi, M. D.

, 19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forward 6/22 Poplar Springs Co. and. DATE OF BURIAL 19 30

20 UNDERTAKER Harry A. Weitzke, ADDRESS 4101 Edmondson Ave.

Spec.—1-30—M. & T.—250 Bks.

42 37337 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58131

M-Burg

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Cameron

(a) RESIDENCE NO. Fort Meyers Fla ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced (HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2-4-26

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Marie McMillan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

14 Informant Nurse

(Address) JOHNS HOPKINS HOSPITAL

JUN 22 1930 H. HAMILTON JAMES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-20-30

17 I HEREBY CERTIFY, That I attended deceased from 5-26-, 1930, to 6-20-, 1930,

that I last saw him alive on 6-20, 1930,

and that death occurred, on the date stated above, at 3.48 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus, congenital

Lye (duration) yrs. mos da.

CONTRIBUTORY (Secondary) Shock Postoperative (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 20-6-30

Was there an autopsy? yes

What test confirmed diagnosis? operation

(Signed) E. H. Campbell Jr. M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburgh Pa DATE OF BURIAL June 23 1930

20 UNDERTAKER John O Pritchett & Sons ADDRESS 1900 Eutaw Place

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58182

CERTIFICATE OF DEATH

E 58182

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2328 W. Lanvale St., Ward 16-68

2-FULL NAME John Thomas Kayer

(a) RESIDENCE NO. 2328 W Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth

6 DATE OF BIRTH (month, day and year): Oct 13-1862

7 AGE: Years 67 | Months 8 | Days 22 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Baker.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Balto
(State or country): Md

PARENTS

10 NAME OF FATHER: Ruth Kayer

11 BIRTHPLACE OF FATHER (city or town): Baltimore
(State or country): Md

12 MAIDEN NAME OF MOTHER: Isabella Rote

13 BIRTHPLACE OF MOTHER (city or town): Baltimore
(State or country): Md.

14 Informant: Mrs Isabelle Kayer
(Address): 2328 W Lanvale St

15 Filed ..... 19 ..... Registrar

Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): June 20th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ..... M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Stampstead Md — DATE OF BURIAL: June 23 1930

20 UNDERTAKER: Robert L Little — ADDRESS: 2200 Edmondson Ave

JUN 22 1930

Registrar

Spec.—1-30—M. & T.—250 Bks.

58183

HEALTH DEPARTMENT—CITY OF BALTIMORE

58183

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE. (No.) 231 E. Lafayette Ave ST. 12-19 WARD)

2-FULL NAME Patricia B. McCleaf

(a) RESIDENCE NO. 231 E. Lafayette Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single
5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 30th 1929

7 AGE — Years | Months: 7 | Days: 22 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Germantown, Pa
(State or country)

PARENTS
10 NAME OF FATHER Daniel E. Fitzgibbons
11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md
(State or country)
12 MAIDEN NAME OF MOTHER Theresa M. McCleaf
13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country) Pittsburgh, Pa

14 Informant Alice M. McCleaf
(Address) 231 E. Lafayette Ave

15 Filed 12-21, 19 30 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21st 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/3, 1930, to 6/21, 1930, that I last saw h[illegible] alive on 6/21, 1930 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:
Myocardial insufficiency

(duration) 5 mos 18 ds.

CONTRIBUTORY (Secondary) Congenital Heart
(duration) Same time yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) H. A. Sigwart, M. D.
(Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park
DATE OF BURIAL 6/23, 1930

20 UNDERTAKER H. B. Wiglust
ADDRESS 850 N. Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

58184

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58184

46

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 161 N. Curly ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma M. Hauer

(a) RESIDENCE NO. 161 N. Curly ST., ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Hauer

DATE OF BIRTH (month, day, and year) Dec. 11, 1875

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	6	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER Joseph King

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Emma Brown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Charles Hauer
(Address) 161 N. Curly St.

15 Filed NOV 22 1930 19 RMC Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1930.

17 I HEREBY CERTIFY, That I attended deceased from February 24, 1929, to June 20, 1930,

that I last saw h.. alive on June 19, 1930

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteres

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb N Athey, M. D.

June 20, 1930 (Address) 1003 Potterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetary

DATE OF BURIAL: Jun. 23 1930.

20 UNDERTAKER: William G. Schaeffer

ADDRESS: 1816E Mon. St

Spec.—1-30—M. & T.—250 Bks.

E 58185

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58185

22

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 - Fillmore St. 19-46 WARD)

2-FULL NAME Franklin T. Hughes

(a) RESIDENCE NO. 1137 - Fillmore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Man	White	Widow

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Eliz. V. Pinkerton

6 DATE OF BIRTH (month, day, and year) 8/12/1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 615

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George Hughes

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mulan

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant James Hughes
(Address) 1137 - Fillmore St.

Filed JUN 2 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 27th, 19 30, to June 30th, 19 30,

that I last saw h[illegible] alive on June 1st, 19 30,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Ascending Impalitis

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Substantial Nephritis

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Geo. Hugo Young M.D., M. D.

6/20, 19 30 (Address) 1400 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 6-23/30. 19

20 UNDERTAKER Mary T. Ruth

ADDRESS 1735 Harford

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58136

CERTIFICATE OF DEATH

90 V E 58136

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 3515 Chestnut ave. St. 13 (Ward)

2-FULL NAME Selor M. Miller.

(a) RESIDENCE NO. 3515 Chestnut ave St., 13 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of Edward Miller.

6 DATE OF BIRTH (month, day, and year) Dec 4-1873

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	56	5	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Co

PARENTS

10 NAME OF FATHER John Zepp

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Howard co

12 MAIDEN NAME OF MOTHER Eliza Hayes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Howard co

14 Informant Edward Miller.
(Address) 3515 Chestnut ave

15 Filed JUN 22 1930 19 C. HAMPSON, Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Neurosis.

Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Morrison, M. D.

6/20, 1930 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	June 23 1930
20 UNDERTAKER H. S. Marshall	ADDRESS 3539 Falls Rd

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 58137 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

90

CERTIFICATE OF DEATH.

E 58137 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1309 Asbury Road ST. 27-54 WARD

2-FULL NAME James R. Leach

(a) RESIDENCE NO. 1309 Asbury Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha E. Sprinkles

6 DATE OF BIRTH (month, day, and year) May 25 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 68

(b) General nature of industry, business, or establishment in which employed (or employer) Public School

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md.

PARENTS

10 NAME OF FATHER Thomas A. Leach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Virginia Helena Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Thos. Walter Leach.

(Address) 1309 Asbury Road

15 Filed JUN 22 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1930

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to June 20, 1930,

that I last saw h[illegible] alive on June 19th 1930

and that death occurred, on the date stated above, at 12 55 a m

The CAUSE OF DEATH* was as follows:

Chronic lung tuberculosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute bronchitis & Complete cystitis

Acute bronchitis (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Robert L. Whitehead, M. D.

June, 1930 (Address) 711 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cemetery DATE OF BURIAL June 22 1930

20 UNDERTAKER W. S. Marshall ADDRESS 559 Fallsway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58188 E 58188

CERTIFICATE OF DEATH

31

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 E. Biddle ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daisy J. Sprague

(a) RESIDENCE NO. 730 E. Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of George W. J. Sprague

7 DATE OF BIRTH (month, day, and year) 1874

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jersey City

10 NAME OF FATHER George Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jersey City New Jersey

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant Mr George J. Sprague
(Address) 730 E. Biddle St

15 Filed 6-23-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1930.

17 I HEREBY CERTIFY, That I attended deceased from Oct 19 1929 to June 21 1930,
that I last saw her alive on June 17 1930
and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) L. M. C. Parker, M. D.

6/23, 1930 (Address) 1114 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL June 23 1930

20 UNDERTAKER Henry Lutz

ADDRESS 1208 N. Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58189

CERTIFICATE OF DEATH

129 E 58189

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern ... Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary R. Rommel

(a) RESIDENCE NO. 1326 N. Central ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Frank J Rommel

7 DATE OF BIRTH (month, day, and year) March 26-1857

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73.	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Ephriam Marten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Rachel Marten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Mrs Freda

(Address) 1326 N Central ave

15 Filed 6/23/30 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 24 1930, to June 20, 1930, that I last saw h[illegible] alive on June 20, 1930, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Osteosarcoma

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction Hopeless

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) A. F. Melcerne, M. D.

19 (Address) 1303 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holly Beachmere

DATE OF BURIAL 6/23/1930

20 UNDERTAKER Robt J Stamm

ADDRESS 1442 W Baltimore

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58190 ✓ E 58190

CERTIFICATE OF DEATH.

52

REGISTERED NO. 42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Little Sisters of Poor ST. 10-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Wallis

(a) RESIDENCE NO. above ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Wallis

6 DATE OF BIRTH (month, day, and year): 1844

7 AGE: Years 85 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar makes.

(b) General nature of Industry, business, or establishment in which employed (or employer): Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: F C Read

(Address): Ft & Greene

15 Filed 2-2 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6 to 30

17 I HEREBY CERTIFY, That I attended deceased from 6/10, 1930, to 6 to 30, 1930, that I last saw h alive on 6/19, 1930, and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH* was as follows:

Senility

Chr Arthritis

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Rimarolows, M. D.

6/24 1930 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 6/23 1930

20 UNDERTAKER: Edward Foulkes

ADDRESS: 2755 E Monument

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

58191 X ✓ E 58191

58191

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 9-45 WARD)

2—FULL NAME S. Tilden Robey

(a) RESIDENCE NO. Hughesville, Chas. Co. Md. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Non Resident yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Appox	54			

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 56

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Alfred Robey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary M. Monroe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. O. Quade

(Address) Hughesville, Md.

15 Filed 2 2 1930 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to June 21, 1930, that I last saw him alive on June 21, 1930 and that death occurred, on the date stated above, at 7.50 P m.

The CAUSE OF DEATH* was as follows:

Typhus Fever

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thyson B. Tull, M. D.

6/21, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Piney Chapel Cemetery, Chas. Co. Md. — DATE OF BURIAL: June 24/30

20 UNDERTAKER: Stewart & Mowen Company — ADDRESS: 108 W. North Ave.

Spec.—1-30—M. & T.—250 Bks

E 58/92 ✓ E 58/92 E 58/92

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

54

REGISTERED NO. E [redacted]

1-PLACE OF DEATH: Balto. City Hosp.

CITY OF BALTIMORE: (NO. 4-25 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Irene Brown

(a) RESIDENCE NO. 531 Sarahann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced: HUSBAND of or) WIFE of: Roy Brown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): O.H.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Ransom Speak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma Hodge

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records of

(Address): Balto. City Hosp.

Filed JUN 22 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-19-30

17 I HEREBY CERTIFY, That I attended deceased from 6-16-30, 19..., to 6-19-30, 19..., that I last saw her alive on 6-19-30, 19..., and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Pellagra 54

(duration) UNKNOWN yrs. mos ds.

CONTRIBUTORY (Secondary) Alcoholism, chronic and acute (duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical ex...

(Signed) Paul Padget, M. D.

6-21, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 6-23 1930

20 UNDERTAKER: Lewis Eichen

ADDRESS 916 Eutaw

1-30—M. & T.—100 B—60L

HEALTH DEPARTMENT—CITY OF BALTIMORE

V-E 58193 V-E 58193 V-E 58193

E 58193

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 N. Bruce ST. 14-27 WARD)

2-FULL NAME Rosie Parker

(a) RESIDENCE NO 314 N. Bruce ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Ed Parker

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H W.
(b) General nature of industry, business, or establishment in which employed (or employer) 37
(c) Name of employer Me

9 BIRTHPLACE (city or town) (State or country) Me

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Culing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Me

14 Informant Arthur Parker

(Address) 314 N. Bruce

15 Filed ....., 192 .... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Indigestion

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. H. Broyle, M. D. Coroner

June 24 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

UNDERTAKER Lemuel Earlam

DATE OF BURIAL 6-23 1930

ADDRESS 216 Orchard.

Spec.—1-30—M. & T.—250 Mm.

58794

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58194 31 E 58194

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 11-24 REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.....ST.....WARD)

2-FULL NAME William Harper (Burroughs)

(a) RESIDENCE NO. 454 St. Mary's st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Nov. 3, 1924

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	7	17	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work --

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

11 NAME OF FATHER William Dent

12 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

13 MAIDEN NAME OF MOTHER Virgie Harper

14 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

15 Informant Hospital Records
(Address)

JUN 22 1930 HAMILTON JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to June 20, 1930, that I last saw him alive on June 20, 1930, and that death occurred, on the date stated above, at 8.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) .....
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) [signature]

6-20-30 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL McCleaburn Bros. DATE OF BURIAL 6-23 1930

20 UNDERTAKER [signature] ADDRESS 916 Eutaw

Spec.—1-30—M. & T.—250 Bks.

E 58195 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58195

CERTIFICATE OF DEATH.

REGISTERED NO.

1.-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2.-FULL NAME William Van Sant. Waynesboro Pa.

(a) RESIDENCE No. 338 W Main St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	S

5a If married, widowed, or divorced HUSBAND of or) WIFE of none.

6 DATE OF BIRTH (month, day, and year) June 17 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18	-	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Wm Van Sant.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Claudie M. Hobbs.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Stanley Van Sant. (Address) Mt. Airy, Md.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/22/30

17 I HEREBY CERTIFY, That I attended deceased from 6-10, 1930, to 6-22, 1930, that I last saw him alive on 6-22, 1930 and that death occurred, on the date stated above, at 2:50 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos 19 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & laboratory

(Signed) Thos. D. Lovick. M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Cemetery. DATE OF BURIAL June 24 1930

20 UNDERTAKER C. M. Matz. ADDRESS Winfield, Md.

20 JUN 1930 C. HAMBLETON JONES, M. D. Registrar

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58196

E 58196

REGISTERED NO. 90

1-PLACE OF DEATH

City of Baltimore: (No. City Jail St., 10-15 Ward)

2-FULL NAME George C. Charles

(a) RESIDENCE NO. — — — St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	colored	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Alexandria
(State or country) Va. Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs Cunningham
(Address) Alexandria Va

15 Filed JUN 21 1930 16 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Under (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Peters, M. D.

June 21, 1930 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Alexandria Va. DATE OF BURIAL June 21, 1930

20 UNDERTAKER Stringfellow & Jones Inc ADDRESS 1639 Broadway

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58197 — CERTIFICATE OF DEATH — 123 — E 58197

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4326 Glenmore Ave. ST. 26-43 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles J. Frank,

(a) RESIDENCE NO. 4326 Glenmore Ave., ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie K.

6 DATE OF BIRTH (month, day, and year) Aug. 14, 1865

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car repairer

(b) General nature of industry, business, or establishment in which employed (or employer) P. R.R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harrisburg, Pa.

PARENTS

10 NAME OF FATHER John Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant M.K. Frank,

(Address) 4326 Glenmore Ave.,

15 Filed June 23 1930. C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 20, 1930

17 I HEREBY CERTIFY That I attended deceased from June, 30 June, 20 30, to, 19 30, (that I last saw him alive on June, 20, 19 30) and that death occurred, on the date stated above, at 11.10 A. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis, Choledocholithiasis.

A severe Jaundice

about three weeks.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, acute dilatation of heart.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L Webster, M. D.

6/24 1930 (Address) 6409 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL June, 23, 30

20 UNDERTAKER William Cook

ADDRESS 217 St. Paul St

Spec.—1-30—M. & T.—250 Bks.

E 58198

HEALTH DEPARTMENT—CITY OF BALTIMORE

125 ✓

CERTIFICATE OF DEATH.

E 58198
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 18-29 WARD)

2-FULL NAME James Feeley

(a) RESIDENCE NO. 123 S. Arlington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 3-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Feeley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Rebaty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Record
(Address)

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22-30

17

I HEREBY CERTIFY, That I attended deceased from 2-17, 1930 to 6-22, 1930,

that I last saw him alive on 6-22, 1930,

and that death occurred, on the date stated above, at 7⁰⁰ a. m.

The CAUSE OF DEATH* was as follows:

Acut. pancreatitis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L.L. Lumpkins, M. D.

6-22, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cem — DATE OF BURIAL 6/24/1930

20 UNDERTAKER Robert J. Cowan & Son — ADDRESS 901 Hollins

JUL 1930 G. W. KIRKUP NOSMITH

Spec.—1-30—M. & T.—250 Blks

E 58199

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 ✓ E 58199

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST., H 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wilson.

(a) RESIDENCE NO. 1720 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Wilson.

6 DATE OF BIRTH (month, day, and year) Jan. 10, 1882.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Wilson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Liza Steyyett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible] Md

14 Informant Records [illegible] (Address) BALTIMORE CITY HOSPITALS

15 Filed 23 1930 C. HARRISON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to June 22, 1930, that I last saw him alive on June 22, 1930, and that death occurred, on the date stated above, at 10:15 A. m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta with aortic insufficiency

more than (duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis.

Chronic (duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical, Microscopic

(Signed) Paul Padget, M. D.

6-22, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Cemetery, Md.

DATE OF BURIAL 6-23-1930

20 UNDERTAKER [illegible]

ADDRESS 916 Eutaw.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58200 155 E 58200

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St., 13-57 WARD)

2-FULL NAME Pauline Mechalski

(a) RESIDENCE NO. 3650 Ash St. City St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX f.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 5, 1916.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ....min.
	14 yrs	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Albert Mechalski

11 BIRTHPLACE OF FATHER (city or town) md.
(State or country)

12 MAIDEN NAME OF MOTHER Myrtle Chatle.

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14 Informant Albert Mechalski.
(Address) 3650 ash St. City

15 Filed 6-23-30, 19 H. W. C. HAWKINS JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-20 1930

17 I HEREBY CERTIFY, That I attended deceased from 6-18, 1930, to 6-20, 1930, that I last saw h alive on 6-20 1930, and that death occurred, on the date stated above, at 8 50 P. m.

The CAUSE OF DEATH* was as follows: daylight saving
Chronic Osteo-myelitis
~~Probable TB~~ Infection

(duration) yrs. mos ovr ds.

CONTRIBUTORY (Secondary) Brain Abscess & Septic-caemia (duration) yrs. mos. 6. ds.

18 Where was disease contracted if not at place of death? at Hospital

Did an operation precede death? yes Date of 11/22/28

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Clinical history

(Signed) Nicholas J. Bonello, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden — DATE OF BURIAL June 24, 1930

20 UNDERTAKER Thurnowe & Son — ADDRESS 3615 Chatsworth Ave

Spec.—2-29-28—L. F. S.—500 Bks.

58201

HEALTH DEPARTMENT—CITY OF BALTIMORE E 58201

CERTIFICATE OF DEATH

REGISTERED NO. 124

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hosp ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Lottie Gorsuch

(a) RESIDENCE NO. 3128 Keswick Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
fem	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. R. Gorsuch.

6b DATE OF BIRTH (month, day, and year) Feb. 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	35	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) W. Va.

(State or country)

PARENTS

10 NAME OF FATHER Richard Williams.

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Susie Statler

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Wm. R. Gorsuch.

(Address) 3128 Keswick Road

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 21, 1930, that I last saw her alive on June 21, 1930 and that death occurred, on the date stated above, at 4 50 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Infarct

4 hours

(duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Cholecystitis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~Cholecystectomy~~

Did an operation precede death? Yes Date of June 19 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical picture

(Signed) Arthur Ratterree, M. D.

6/21, 1930 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Pleasant Carroll Co

DATE OF BURIAL June 24 1930

20 UNDERTAKER Thanhouser Son

ADDRESS 3615 Chestnut Ave

Spec.—1-12-23—M&T—500 Blks.

E 58202

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58202

74 601

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Clarkson St. 23-32 WARD)

2-FULL NAME Albert F. Klein

(a) RESIDENCE NO. 1609 Clarkson ST. 23 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charlotte Klein

6 DATE OF BIRTH (month, day, and year): Dec 2nd 1856

7 AGE: Years 73 | Months 6 | Days 18 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED:
(a) Trade, profession or particular kind of work: Basket Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germy

PARENTS

10 NAME OF FATHER: Earl Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germy

12 MAIDEN NAME OF MOTHER: Finkenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germy

14 Informant: Charlotte Klein
(Address): 1609 Clarkson st.

15 Filed JUN 23 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 20, 1930, that I last saw h alive on June 19, 1930 and that death occurred, on the date stated above, at 6-25 A m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary): Obstruction (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. K. Campbell, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. — DATE OF BURIAL: June 23rd 1930

20 UNDERTAKER: E. Schlomann & Son — ADDRESS 1039 Hanover

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58203

CERTIFICATE OF DEATH

89 1

E 58203

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 Chilton ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Virginia Crockett

(a) RESIDENCE NO. 1723 Chilton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Humphry Crockett

DATE OF BIRTH (month, day, and year) Dec 24 1857

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	5	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Prince George Co Md

10 NAME OF FATHER John Cross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Abney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Myrtle V. Crockett

(Address) 1723 Chilton St

15 Filed ... 19 C. HARRISON JONES, M. D. Registrar

2 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1930

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1930 to June 20, 1930

that I last saw h. alive on June 19, 1930

and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Coon, M. D.

6/24, 1930 (Address) 413 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL June 23 1930

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58204

CERTIFICATE OF DEATH.

100-001

E 58204

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. St. 18-7b WARD)

2-FULL NAME Mary Bree

(a) RESIDENCE NO. 809 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. Was born in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1867?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record (Address)

15 Filed 12 31 1930 19 R. Hampson Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-19-30

17 I HEREBY CERTIFY, That I attended deceased from 6-6, 1930, to 6-19, 1930, that I last saw her alive on 6-19, 1930, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic ulcerations and abscesses of legs.

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Pumphrey, M. D.

6-19, 1930 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Couri's Maryland DATE OF BURIAL June 23 1930

20 UNDERTAKER Joseph A. Lively ADDRESS 409 Fremont St

Spec.—1-30—M. & T.—250 Bks

E 58205 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58205

CERTIFICATE OF DEATH.

REGISTERED NO. 154-001

1-PLACE OF DEATH N. W. H. ST., 1349 WARD)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Talbot Buffington

(a) RESIDENCE NO. Tudor arms apts ST., ... WARD ..... (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 20, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Edward W. Buffington

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Annabelle Hardy

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Edward Buffington
(Address) 1201 N. Calvert St

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22-30

17 I HEREBY CERTIFY, That I attended deceased from 6/22/30, 19..... to June 22, 1930, that I last saw her alive on June 22, 1930, and that death occurred, on the date stated above, at 7:17 A.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

~~Hydrocephalus, Congenital~~

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Congenital Hydrocephalus

(duration) ..... yrs. 7 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj Tappan, M. D.

6-22, 1930 (Address) 1201 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL June 23 1930

UNDERTAKER H. HARRISON JONES, M.D.

ADDRESS 1201 N. Calvert St

Spec.—1-12-23—M&T—500 Blks.

E 58206

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58206

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 668 W Saratoga St. 4-25 WARD)

2-FULL NAME Noah Hankins

(a) RESIDENCE NO. 668 W Saratoga ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: col.

5 Single, Married, Widowed, or Divorced. (Write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Hankins

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country)

14 Informant (Address) Rosie Edwards 668 W Saratoga St.

15 Filed JUN 23 1930 19 C. H. JONES, M. D. Registrar

ET

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-20-1930

17 I HEREBY CERTIFY, That I attended deceased from 6-7-, 1930, to 6-20, 1930, that I last saw h— alive on 6-16-, 1930 and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. Hankins M. D.

6/20, 1930 (Address) Boonsboro Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

UNDERTAKER: Mrs Katie P. Williams

DATE OF BURIAL: June 23, 1930

ADDRESS 322 N. Schroeder St.

Spec.—1-30—M. & T.—250 Blks

21080 HEALTH DEPARTMENT—CITY OF BALTIMORE 6-991 E 58207.

E 58207 CERTIFICATE OF DEATH STH. BIRTH NO. 21080

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 N. Population ST. 18-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johnson

(a) RESIDENCE NO. 224 N. Population ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): 6/21/30

7 AGE — Years: — Months: — Days: — If LESS than 1 day, hrs. or min.: 20 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Bradley Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Charlotte Co Virginia

12 MAIDEN NAME OF MOTHER: Annie Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Charlotte Co Virginia

14 Informant: Bradley Johnson

(Address): 224 N. Population

Filed JUN 23 1930 G. HUDSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/22/30

17 I HEREBY CERTIFY, That I attended deceased from 6/21, 1930, to 6/22, 1930, that I last saw h alive on 6/21, 1930, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows: Premature birth — 6 mo Duration —

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): None —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None —

(Signed) Dan Francheim, M. D.

6/23, 1930 (Address) 1x x x Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: June 23, 1930

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58208

CERTIFICATE OF DEATH.

31

E 58208

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospitals ST. 26-1 WARD)

2-FULL NAME Charles Lohn

(a) RESIDENCE NO. 926 S. Clinton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced
HUSBAND of (or WIFE of) Wife- Alma Lohn

7 DATE OF BIRTH (month, day and year) Jan. 1 1882

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Canton R.R.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm. Lohn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Kemp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hosp. records

15 Filed JUN 30 1930 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22-30

17 I HEREBY CERTIFY, That I attended deceased from 6-18 ....., 1930, to 6-22 ....., 1930,

that I last saw h..... alive on 6-22 ....., 1930,

and that death occurred, on the date stated above, at 12.15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Jas Stevens Jr. M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz's Cemetery

UNDERTAKER George W. Zickler

DATE OF BURIAL June 25, 1930

ADDRESS 1737 E. Eager St

Spec.—1-12-23—M&T—500 Blks.

58209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 E 58209

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen. Hosp. St. 17-56 WARD)

2-FULL NAME Mrs. Elizabeth Parlett

(a) RESIDENCE NO. 3339 W Belvedere Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs 4 mos 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of George W. Parlett

6 DATE OF BIRTH (month, day, and year) Feby 15 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	77	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Buckheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Wetzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant E. F. Parlett (Address) 1st Preston St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/21 1930

17 I HEREBY CERTIFY, That I attended deceased from 6/11, 1930, to 6/21, 1930, that I last saw her alive on 6/21, 1930, and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Autopsy

(Signed) J. A. Olesen, M. D.

, 19 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL June 24th 1930

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument St

Spec.—1-30—M. & T.—250 Blks

58219

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 58210

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST., 7-K WARD)

2-FULL NAME Mary Jones

(a) RESIDENCE NO. 920 N. Patterson Park Ave. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown 1845

6 DATE OF BIRTH (month, day, and year) Oct 4, 1846 (?)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84? 10?	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress. 064

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Jones

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Records of Baltimore City Hospitals
(Address)

15 Filed JUN 23 1930 H. RANDALL JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to June 21, 1930, that I last saw h.e.y. alive on June 21, 1930, and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic + acute.

(duration) Unknown. yrs. mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Unknown yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam

(Signed) Paul Podgel. M. D.

6-22 1930 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Mem. Co.

DATE OF BURIAL 6/24 1930

20 UNDERTAKER J. J. Moran

ADDRESS 3000 E. Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58211 162 **E 5821T**

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5152 Calhoun ST. 19-26 WARD)

2—FULL NAME Martha Scott

(a) RESIDENCE NO. 5152 Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word):

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James J Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lizzie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant .....

(Address) .....

Filed JUN 23 1930 R.M.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to June 21, 1930, that I last saw h[illegible] alive on June 21, 1930, and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis (Premature 6 month)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. H. Baldwin, M. D.

, 19 (Address) 1503 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS JUN 23 1930

Spec.—1-30—M. & T.—250 Bks.

237936

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58212

CERTIFICATE OF DEATH.

16-002

E 58212

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 13-51 (WARD)

2-FULL NAME Mary Thomas

(a) RESIDENCE NO. Florence Crittenden Home ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1 - 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Mary Bonnisti

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 23 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1930

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1930, to June 17, 1930, that I last saw her alive on June 17, 1930, and that death occurred, on the date stated above, at 345A m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Dysentery, Prematurity

(duration) yrs. mos 7 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Florence Crittenden Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. V. Bickford, M. D.

6/17 1930 (Address) JHH.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS JUN 23 1930

HARRISON JONES

Spec.—1-30—M. & T.—250 Bks

58213

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 58213

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 144 W. Hamburg ST. 23-31 WARD)

2-FULL NAME Josephine Bell

(a) RESIDENCE NO. 144 W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. + mos. + ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Lorenzo Bell -

6 DATE OF BIRTH (month, day, and year) Jan 7 1883

7 AGE: Years 47 | Months 5 | Days 14 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Days Work

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kent Island Maryland

PARENTS

10 NAME OF FATHER: John Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kent Island Maryland

12 MAIDEN NAME OF MOTHER: Mary J Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Island Maryland

14 Informant: John W Parker

(Address) 10 [illegible]

HAMILTON JONES, M. D.

Filed JUN 23 1930 Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/21/30

17 I HEREBY CERTIFY, That I attended deceased from 6/10, 1930, to 6/21, 1930, that I last saw h[illegible] alive on 6/20 1930, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) Chronic ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Dan Lowndes, M. D.

6/23 1930 (Address) 122 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] Cemetery — DATE OF BURIAL: June 26 1930

UNDERTAKER: W. H. Brown & Son — ADDRESS: 108 W. Mon[illegible]

Spec.—1-30—M. & T.—250 Blks.

38153
58214

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 58214

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 3-4 WARD)

2-FULL NAME William Johnson

(a) RESIDENCE NO. 402 S Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of alice

6 DATE OF BIRTH (month, day, and year) Jan-12-1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Susie Garland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-21-1930

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1930, to June 21, 1930, that I last saw h.. alive on June 21, 1930, and that death occurred, on the date stated above, at 4.15 a. m.

The CAUSE OF DEATH* was as follows:

Hemoptysis — Cause undetermined. (Coroner)

5 minutes (duration) ....yrs. ....mos ....da.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? YES

What test confirmed diagnosis? —

(Signed) Hedwig Kaump, M. D.

, 19 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn ct

DATE OF BURIAL June 21, 1930

20 UNDERTAKER W. A. Brown & Son

ADDRESS 108 a. Mount

Spec.—1-30—M. & T.—250 Bks.

38039 37-001 E 58215

58215

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL ST., 17-24 WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME James Johnson

(a) RESIDENCE NO. 534 Oxford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov-19-1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Catharine Borsley

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19.. C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-20-1930

17 I HEREBY CERTIFY, That I attended deceased from June-16, 1930, to June 20, 1930, that I last saw him alive on June 20, 1930, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

acute Miliary Tuberculosis

Tuberculous Meningitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J W Bickford, M. D.

6/20 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

UNDERTAKER D. [illegible]

DATE OF BURIAL 19

ADDRESS

JUN 23 193 [illegible] Commissioner Health

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58816 ✓ 46 E 58216

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 773 W. Cross St. WARD) 24-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eliza Rebecca Meeks

(a) RESIDENCE NO. 773 W. Cross St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 4 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word)
Female	white	widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Meeks

DATE OF BIRTH (month, day, and year) Feb 20 18[illegible]

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	4	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Jacob Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Louisa Nash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Walter C. Meeks

(Address) 773 W. Cross St.

15 Filed 6/23 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1930

17 I HEREBY CERTIFY That I attended deceased from Jan 10, 1930, to June 22, 1930

That I last saw h[illegible] alive on June 21, 1930

That death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia F Other

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Phantom

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) [illegible], M. D.

6/24, 1930 (Address) 5[illegible] Lord

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 25 1930
20 UNDERTAKER	ADDRESS
J. A. Saunders Son	2173 P[illegible]

Spec.—1-30—M. & T.—250 Blks.

237183
E 58217

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58217

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST., 7-9 WARD)

2-FULL NAME Dr Cuthbert Thompson

(a) RESIDENCE NO. Louisville Ky ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Julia

6 DATE OF BIRTH (month, day, and year) Sept-14-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Gabella Getty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

Filed 2-3-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-23-1930

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to June 23, 1930, that I last saw h[illegible] alive on June 23, 1930, and that death occurred, on the date stated above, at 5-30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. W. Lorimer M. D.

, 19 (Address) J. E. Church.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louisville Kentucky

DATE OF BURIAL 6/23 1930

20 UNDERTAKER Physicians Cook

ADDRESS 1217 St Paul

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58218

CERTIFICATE OF DEATH.

E 58218

REGISTERED NO. 161-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. (or) WARD 26-37

2-FULL NAME Pauline Reedy

(a) RESIDENCE No. 3501 Foster ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16-1930

7 AGE — Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Reedy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 23 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17-1930

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to , 19 ,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at 10 50 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) S. O. Y. Warren, M. D.

6-19, 1930 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER (Official)

ADDRESS

JUN 23 1930

Spec.—1-30—M. & T.—250 Blks.

E 58219 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58219

CERTIFICATE OF DEATH.

X 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

2-FULL NAME Harry D Drake

(a) RESIDENCE NO. Sparrows Point, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Elizabeth Drake

6 DATE OF BIRTH (month, day, and year) Oct 8 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Elizabeth K Drake

(Address) Lincoln Ave Sparrows Point Md

15 Filed JUN 23 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1930

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1930, to June 22, 1930,

that I last saw h~~im~~ alive on June 22, 1930,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 3 3 ds.

CONTRIBUTORY (Secondary) Infarct of left lung

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Sparrows Point

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical signs

(Signed) Lewis P Yeomans, M. D.

June 22 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bachmans

DATE OF BURIAL June 25 1930

20 UNDERTAKER John F Derry

ADDRESS 715 Light St

Spec.—1-30—M. & T.—250 Bks.

E 58220 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58220

237

CERTIFICATE OF DEATH.

REGISTERED NO. 16

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Lee Bowers

(a) RESIDENCE NO. 310 E Fayette St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7/6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

3a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug-16-1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	2	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— ——

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md-
(State or country)

PARENTS

10 NAME OF FATHER Robt. L. Bowers

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Lottie Carroll

13 BIRTHPLACE OF MOTHER (city or town) Md-
(State or country)

14 Informant Friends-
(Address) JOHNS HOPKINS HOSPITAL

15 3 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21-30

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1930, to June 21, 1930, that I last saw her alive on June 21, 1930, and that death occurred, on the date stated above, at 7 00 P.M.

The CAUSE OF DEATH* was as follows:

Enteritis
(Dysentery)

(duration) yrs. mos 13 days

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. W. Bickford, M. D.

6/22 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL June 24 1930

20 UNDERTAKER 7 Vernon Kellner

ADDRESS 1532 Hollins

Spec.—1-30—M. & T.—250 Blks.

E 58221 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58221

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3539 Roland Ave ST., 13 (13-52) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel E. Goodman

(a) RESIDENCE No. 3539 Roland Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

6a If married, widowed, or divorced HUSBAND of or) WIFE of Florence L. Goodman

6 DATE OF BIRTH (month, day, and year) June 1-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 509

(b) General nature of industry, business, or establishment in which employed (or employer) Lunch Room

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tomsbrook, Va.

PARENTS

10 NAME OF FATHER William O. Goodman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elmira Borden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Lillian L. Goodman

(Address) 2237 E. North Ave

Filed 2-3-1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22-1930

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1929, to June 22, 1930, that I last saw h[illegible] alive on June 22, 1930, and that death occurred, on the date stated above, at 6.40 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Carditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Clinical Findings

(Signed) J. N. Nelson M. D.

, 19 (Address) 848 W. 36th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL June 24 1930.

UNDERTAKER Horace H. Bruce — ADDRESS 3631 Falls Road

Spec.—2-29-28—L. F. S.—500 Bks.

E 58222 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 **E 58222**

CERTIFICATE OF DEATH

1—PLACE OF DEATH Home for Incurables REGISTERED NO. 27-53

CITY OF BALTIMORE: (No. 40-55 & Keswick Rd ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rachael Jane Gilmour

(a) RESIDENCE NO. 108 Buchdale Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) July 18-1874

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
55	56	11	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particulsr kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) Elkton, Md.
(State or country)

10 NAME OF FATHER William O. Gilmour

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Elkton. Md.

12 MAIDEN NAME OF MOTHER Jane McCauley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Elkton - Md.

14 Informant Home for Incurables Records
(Address) 40th St & Keswick Rd.

15 FILED 3 1930 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23-1930

17 I HEREBY CERTIFY, That I attended deceased from June 1 1930 to June 23 1930, that I last saw h[illegible] alive on June 23 1930 and that death occurred, on the date stated above, at 12:30 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism

9 hours.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Had had Lobar pneum-monia - was convalescent
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) H. S. Willis, M. D.

19 (Address) Med. Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton Cemetery — DATE OF BURIAL June 25 1930

20 UNDERTAKER H. W. Offpin — ADDRESS Elkton, Md.

Spec.—1-30—M. & T.—250 Bks

E 58223 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58223

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 21-29 ST. WARD)

2-FULL NAME John Bell

(a) RESIDENCE NO. 1201 (?) W. Ostend St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer) Produce

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. W. Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 6-23-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22-30

17 I HEREBY CERTIFY, That I attended deceased from 5-27-30, 19..., to 6-22-30, 19..., that I last saw him alive on 6-22-30, 19..., and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombosis cerebral artery (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? 1. Home. 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett, M. D.

6-25, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 6/25/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

1-30—M. & T.—100 B—50L

E 58224

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58224

REGISTERED NO. 188-203

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Balto Hos ST. 7-1-24 (WARD)

2-FULL NAME Annie Banks

(a) RESIDENCE NO 120 E Ostend St ST., WARD

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos A. Banks

6 DATE OF BIRTH (month, day, and year) June 4-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Gordon Wade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Beasley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Maggie Carson

(Address) 1021 Ward St

15 Filed ....., 192 C. HAMPSON JONES, M. D. Registrar

3-7-30 Per NCK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto accident in which she was a passenger overturned Crushing

(duration) yrs mos da

CONTRIBUTORY (Secondary) Tract Stroke

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? Frederick Rd

Did an operation precede death? no Date of a a Co.

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D. Coroner

June 23, 1930 (Address) 2939 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Melvale Cemetery Elkridge Md.

DATE OF BURIAL June 24 1930

20 UNDERTAKER Bernard A Fink

ADDRESS 184 Washington Blvd

1-30—M. & T.—100 B—50L

E 58225

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-00 E 58225

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Enroute to Hopkins Hospital St. 8-12 WARD)

2-FULL NAME Charles W. Cullum

(a) RESIDENCE NO 2300 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 — 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Wodower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of S. Elizabeth Cullam

6 DATE OF BIRTH (month, day, and year) June 22/1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	03	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Electric Commission

(c) Name of employer Balto., City

9 BIRTHPLACE (city or town) (State or country) Harford Co., Md

PARENTS

10 NAME OF FATHER Jesse Cullam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rose Salvage

(Address) 2300 E. Biddle St

15 Filed 6/23 1930 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure-Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Odema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. H. Jones, M. D. Coroner

6/23/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL June 25 1930

20 UNDERTAKER George W Zutter

ADDRESS 1737 Eyer

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58226 — CERTIFICATE OF DEATH — 90 E 58226

REGISTERED NO. 15-61

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3209 Windsor Avenue ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Jordan Thomsen

(a) RESIDENCE NO. 3209 Windsor Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Locke Thomsen

DATE OF BIRTH (month, day, and year) Dec - 11 - 1852

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	6	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Laurence Thomsen

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily J. Jones

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Rev. Samuel L. Thomsen

(Address) Nelson Iceland, Md.

15 Filed ....., 19.... Per ..... Registrar

C. HAMPSON JONES, M. D.

2 31 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23/30

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1930, to June 23rd, 1930, that I last saw him alive on June 7 2nd, 1930, and that death occurred, on the date stated above, at 6.40 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs and symptoms

(Signed) Earl W. Lovell Dal M. D.

June 23, 1930 (Address) 613-615 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cemetery

DATE OF BURIAL June 26/30

19a UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Manager)

ADDRESS 108 W. NORTH AVE.

Cor.—10-10-29—A Co.—100 Bks.

E 58227

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 58227

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2731 Elkhorn St., 12-51 Ward)

2-FULL NAME Ida Jane Payne.

(a) RESIDENCE NO. 2729 Elkhorn St., 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Payne

6 DATE OF BIRTH (month, day, and year) Dec 2 1874

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
56	55	6	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER August Wattenschett

11 BIRTHPLACE OF FATHER (city Germany
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Herman

13 BIRTHPLACE OF MOTHER (city or Germany
(State or country)

14 Informant Madeline Bergmann
(Address) 318 E 27th St

15 Filed 6 1930 C. HAMPSON JONES, M. D. Registrar
Per RBH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Heart

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

6/22 1930 (Address) 3622 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	6/24 1930
20 UNDERTAKER Steele & Co	ADDRESS 1200 Hollins St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58228

CERTIFICATE OF DEATH

+179 E 58228

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4-30 Ward)

2-FULL NAME Julia M. Davis

(a) RESIDENCE NO. Woodstock, Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Davis

6 DATE OF BIRTH (month, day and year) Unknown 1848

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	82	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER C. Howard Owings

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Owings

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Richard Davis
(Address) Woodstock, Md

3 1930 C. HAMPSON JONES, M. D. Registrar

Reg'r

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy (or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st degree burns of entire body. Accidental Death. Burnt while attempting to put out bush-fire

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fillers, M. D.

6/23 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. View Cem. DATE OF BURIAL June 25 1930

20 UNDERTAKER Easton Sons ADDRESS Elliott City

Important. See instructions on back of certificate.

ret.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58229

CERTIFICATE OF DEATH

90 E 58229

1—PLACE OF DEATH

REGISTERED NO. 37

CITY OF BALTIMORE: (No. 401 So. Lehigh Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick Gaylord Johnson

(a) RESIDENCE NO. 401 So. Lehigh Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of: None.

DATE OF BIRTH (month, day, and year): 1876

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	Unknown.		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Weigher in

(b) General nature of industry, business, or establishment in which employed (or employer): Steel Mill

(c) Name of employer

BIRTHPLACE (city or town) (State or country): New York City

10 NAME OF FATHER: John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): U. S. A.

12 MAIDEN NAME OF MOTHER: Elizabeth Bdydon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catherine Runyon

(Address) 84 St NY city

15 Filed ..... 19 .....

2 3 1930

C. HAMPSON JONES, M.D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1— 1930, to June 23 1930,

that I last saw h.. alive on June 22nd 1930,

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic Degeneration Myocarditis

(duration) yrs. mds. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - Uremic Poisoning

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris J. Sherman M.D., M. D.

19 (Address) 415 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New York N.Y. June 24 1930

DATE OF BURIAL

20 UNDERTAKER: John C. Miller 2435 E

ADDRESS: Alinco

pec.—1-30—M. & T.—250 Bks.

E 58230

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 ✓ E 58230

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509-N. Wolfe St. 8-17 WARD)

2-FULL NAME Sarah E. Whorton

(a) RESIDENCE NO. 1509-N. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Fifty yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of Charles E. Whorton

6b DATE OF BIRTH (month, day, and year) 6/1/1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Agustus Juerss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Regina Batzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Joseph John

(Address) 1509 N. Wolfe St

15 Filed JUN 24 1930 C. Harry Johns M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1930, to June 22, 1930,

that I last saw h.y alive on June 21, 1930

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left Breast & appendages

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 1929

Was there an autopsy? No

What test confirmed diagnosis? Laboratory tests

(Signed) C. Hartley Simonds M. D.

6/23/1930 (Address) 1635 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 6/25/1930

20 UNDERTAKER Mary E. Ruth Sons

ADDRESS 1735 Hartford Ave

Cor.—10-10-29—A Co.—100 Bks.

58231

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 58231

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins St., 9-17 Ward)

2-FULL NAME Grandvil Coleman

(a) RESIDENCE NO. 1818 N. Spring St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/26/1929

7 AGE	Years	Months	Days	IF LESS than 1 day	hrs. or	min.
	1	1	28	X		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Thomas Coleman

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Agnes Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Thomas Coleman
(Address) 1811 N. Eutaw St

15 Filed JUN 24 1930 C. HAMILTON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pertussis Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Hall, M. D.

6/23 1930 (Address) 5086 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery — DATE OF BURIAL 6/24/30

20 UNDERTAKER Mary V. Ruth — ADDRESS 1931 Hoffman

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

Cleaver.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58232

58232

CERTIFICATE OF DEATH.

139

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 16-40 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Violet Cleaver

(a) RESIDENCE NO. 3028 Kenyon ave ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Henry F. Cleaver

6 DATE OF BIRTH (month, day, and year) May 4, '94

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Rhea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records

(Address)

15 6/24 1930 J. C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23-30

17 I HEREBY CERTIFY, That I attended deceased from 6/17/30, 19..., to 6/23/30, 19...,

that I last saw h[illegible] alive on 6/23/30, 19...,

and that death occurred, on the date stated above, at 4:35 P.m.

The CAUSE OF DEATH* was as follows:

Fibroid uterus

[illegible] (duration) ...yrs. ...mos ...ds.

CONTRIBUTORY (Secondary) Pentothal (duration) ...yrs. ...mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/15/30 6/24/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

6/23, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edmondson Burying Ground Dorchester Co Md

DATE OF BURIAL June 24 1930

20 UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Ave

Spec.—1-30—M. & T.—250 Bks

E 58233

E 58233 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8-45 X 90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1634 Darley Ave. (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William. R. Heverin

(a) RESIDENCE NO. 1634 Darley Ave. ST., WARD Delaware

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 4 ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Millworker & Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER David Heverin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Bessie (Address) 1634 Darley Ave

15 FILED 2-4 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-23-1930

17 I HEREBY CERTIFY, That I attended deceased from 6-20- 1930, to 6-23- 1930,

that I last saw him alive on 6-23-30 19 daylight saving

and that death occurred, on the date stated above, at 8:45 A.M. 7.45 A.M. Standard time

The CAUSE OF DEATH* was as follows:

Myocarditis -

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) George A. Bowden, M. D.

6/24, 1930 (Address) 1517 E Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL June 26 1930

20 UNDERTAKER Henry Heath Sons Inc

ADDRESS 1301 E Eager St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 58234

E 58234

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Forest St ST. 10-15 WARD)

2-FULL NAME John A Boyle

(a) RESIDENCE. NO. 1107 Forest St ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22nd 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	57	0	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER David J. Boyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Dolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas Boyle
(Address) 2618 Maryland Ave

15 Filed ..... 19 ..... HAMILTON JOHNS, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930 to June 23, 1930
that I last saw him alive on June 23, 1930,
and that death occurred, on the date stated above, at 2:30 P m.
The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage
Sudden
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Richard Dorsey M.D.
19 30 (Address) 1112 W 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	6/25/1930
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Blks.

25-613
E 58235

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 58235

CERTIFICATE OF DEATH.

+ 97-007

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 12-30 ST., WARD)

2-FULL NAME Nathaniel Farnsworth

(a) RESIDENCE NO. 312-East-25th ST ST., WARD Sanford-Florida
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 4-1864

7 AGE — Years: 75 — Months: 7 — Days: 18 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Agricultural Expert

(b) General nature of industry, business, or establishment in which employed (or employer): 08

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10 NAME OF FATHER Thos. Farnsworth

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER Rachael Sutcliffe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Wife (Address) JOHNS HOPKINS HOSPITAL

15 Filed 6-24-1930, 19... C. HARRISON ORRIS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22-30

17 I HEREBY CERTIFY, That I attended deceased from Apr. 7, 1930, to June 22, 1930, that I last saw him alive on June 22, 1930, and that death occurred, on the date stated above, at 2 27 P. m.

The CAUSE OF DEATH* was as follows:

Brain Abscess

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Florida

Did an operation precede death? Yes Date of 4-6-30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Chas Sprague 2nd, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill Cem. | DATE OF BURIAL: June 26 1930

20 UNDERTAKER: Thos. O. Mitchell & Sons. ADDRESS 1910 Eastern Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58236

CERTIFICATE OF DEATH.

E 58236

REGISTERED NO. 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) Wilkins & Caton Avenues ST. 20-69 WARD)

2-FULL NAME Baby Boy Stevens.

(a) RESIDENCE NO. 150 N. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. Boy

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-21-30.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

2 Days

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles F. Stevens.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Rosie E Davis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Charles F. Stevens
(Address) 150 N. Bentalou St

Filed 6-24 1930. 19 [illegible] Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1930

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1930, to June 23, 1930, that I last saw h[illegible] alive on June 22, 1930, and that death occurred, on the date stated above, at 1 P m. Standard Time

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos 2d ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M.D.

6/23 1930 (Address) 1729 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL June 24 1930

20 UNDERTAKER Chas. F. Stevens

ADDRESS 1301 E Fort

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Gabolauskey

E 58237

CERTIFICATE OF DEATH.

E 58237

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1009 E. Fayette St. 5-8 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Gabolauskey

(a) RESIDENCE NO. 1009 Fayette E St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE: Years 80 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: Samuel Gabolauskey

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Russia

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country):

14 Informant: Anna Schwartz

(Address): 2151 E. Baltimore

Filed 2-4 1930, 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cor. Amb. Pneumonia

Arteriosclerosis (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

Jan 29 1930 (Signed) [illegible] M. D.

(Coroner)

(Address) 1659 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rodedale — Date of Burial 6/24 1930

20 UNDERTAKER: S. Levinson Bros — ADDRESS 1127 E Balto St

Very Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 58238

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58238

48

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Jewish Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 13-54 ST. WARD)

2-FULL NAME Master Isaac H. Davidson

(a) RESIDENCE NO. 2301 Brookfield Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 14, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Lee Davidson

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Theresa Gordon

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mrs Lee Davidson

(Address) 2301 Brookfield Ave

15 Filed JUN 24 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1930

17 I HEREBY CERTIFY, That I attended deceased from June 18 1930 to June 23 1930

that I last saw him alive on June 23 1930,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of scalp

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Generalized sarcomatosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Milton B Lurie, M. D.

19 (Address) Jewish Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 6/24 1930

20 UNDERTAKER Harris Sondheim & Son

ADDRESS 1902 Eutaw Place

pec.—1-30—M. & T.—250 Bks.

E 58239 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 58239

CERTIFICATE OF DEATH.

REGISTERED NO. 1561

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3029 WINDSOR AV ST. 15 WARD)

2-FULL NAME ROBERT S. BRADY

(a) RESIDENCE No. 3029-WINDSOR AVE ST., 15 WARD 15

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	WIDOWED

If ~~married~~, widowed, ~~or divorced~~ WIDOWER

HUSBAND of (or) ~~WIFE of~~ JOSEPHINE CLARA BRADY

DATE OF BIRTH (month, day, and year) AUG. 11 - 1851

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
79	79	10	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work SECRETARY

(b) General nature of industry, business, or establishment in which employed (or employer) SEMINARY

(c) Name of employer ST. JOSEPH'S SEMINARY

BIRTHPLACE (city or town) (State or country) BALTIMORE MD.

PARENTS

10 NAME OF FATHER JOHN K. BRADY

11 BIRTHPLACE OF FATHER (city or town) BALTIMORE (State or country) MD

12 MAIDEN NAME OF MOTHER MARY RUMSEL

13 BIRTHPLACE OF MOTHER (city or town) (State or country) GERMANY

14 Informant Helen R. Schemmagel. (Address) 32 [illegible] MADISON AVE, MT. VERNON PLACE

Filed JUN 24 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUNE 22-1930

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to June 22, 1930, that I last saw him alive on June 20, 1930, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 10 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 10 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) G W Bullup, M. D.

, 19 (Address) 2224 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL NEW CATHEDRAL CEM.

DATE OF BURIAL 6-25 1930

20 UNDERTAKER HENRY W. JENKINS' SON CO

ADDRESS ORCHARD McCULLOH. St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58240

CERTIFICATE OF DEATH.

31 E 58240

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N. Gilmor ST., 14-27 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Young

(a) RESIDENCE NO. 400 W Gilmor ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (HUSBAND of) or (WIFE of) John Young

6 DATE OF BIRTH (month, day, and year) ? ? 1904

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
26	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) Greenville (State or country) U.S.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant John Young
(Address) 400 N Gilmor

15 Filed ..... 19 ... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1930

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1930, to June 21, 1930

that I last saw her alive on June 19, 1930

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) ... yrs. 5 mos ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. F. Howell, M. D.

6/22/30 (Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL June 25 1930

UNDERTAKER John H. Toadvine

ADDRESS 1027 Druid Hill

rec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58241

CERTIFICATE OF DEATH

90 V

E 58241

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 730½ Franklin ST. 17-16 WARD)

2—FULL NAME Sarah V. Thomas.

(a) RESIDENCE NO. 730½ Franklin ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	col	Widow

6 If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Chas. Thomas

DATE OF BIRTH (month, day, and year) 1876

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
54	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) ~~Baltimore~~ Md

10 NAME OF FATHER David Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Hanbson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edward Wilson

(Address) 730½ N. Franklin

15 Filed JUN 24 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22/30

17 I HEREBY CERTIFY, That I attended deceased from May 29 1930, to June 21 1930

that I last saw h~~er~~ alive on June 21, 1930

and that death occurred, on the date stated above, at 3.50 A. M. D.S.T.

The CAUSE OF DEATH* was as follows:

Tabular Disease
Heart.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin. exam.

(Signed) Paula E. Nauert M. D.

6/22, 1930 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	24th 1930
UNDERTAKER	ADDRESS
Frank Brumbaugh	578 N. Eutaw

Cor.—10-10-29—A Co.—100 Bks.

E 58242

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58242

CERTIFICATE OF DEATH

181

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 704 W. Redwood St., 4-30 Ward)

2-FULL NAME Manuel Gonzales

(a) RESIDENCE NO. 704 W. Redwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Continuous How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Porto Rico

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Dorothea Carroll
(Address) 704 W. Redwood St

15 Filed ..... 19.. C. HARRISON ROBERTS, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Poisoned by illuminating gas. Probably due to acute alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

6/23. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 24 1930
20 UNDERTAKER	ADDRESS
Dan'l Easton	Dover.

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

Caroline Schoenlatz

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58243

E 58243

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1. PLACE OF DEATH: Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ____ ST., 7-L WARD)

2. FULL NAME: Caroline Schoenlatz

(a) RESIDENCE NO. 724 N. Linwood Ave. ST., ____ WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank X. Schoenlatz

7 DATE OF BIRTH (month, day, and year): March 27 ?

8 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	74 ?	3	25	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

10 BIRTHPLACE (city or town) (State or country): Bavaria

PARENTS

10 NAME OF FATHER: ? Santleiter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bavaria

12 MAIDEN NAME OF MOTHER: Marg. Fleischman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Records of

(Address): Balto. City Hosp.

15 Filed JUN 24 1930 C. HARRY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-22-30

17 I HEREBY CERTIFY, That I attended deceased from 6-17-30, 19____, to 6-22-30, 19____,

that I last saw her alive on 6-22-30, 19____,

and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. ____ mos ____ ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) ____ yrs. ____ mos. 5 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? Exam. lab.

(Signed) Paul Padget, M. D.

6-23-30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery

DATE OF BURIAL: June 25 1930

20 UNDERTAKER: J. Lilly + Sister Inc.

ADDRESS: 400 S. Wolfe St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58244

CERTIFICATE OF DEATH

90 ✓

E 58244

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 529 E Bond St., 2-4 Ward)

2-FULL NAME Robt Moffett

(a) RESIDENCE NO. 529 E Bond St., 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) " "
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Walter Dobrzynski
(Address) 3118 Tait Ave

15 Filed ....., 19.... JAMES H. JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1930

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ex Lailshon

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? By History

(Signed) C C Hagen, M. D.

19 30 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	June 25 1930
20 UNDERTAKER Lally & Gilden Inc	ADDRESS 4032 Wash Blvd

Important. See instructions on back of certificate.

spec.—1-30—M. & T.—250 Bks.

E 58245 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58245

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 E. Chase ST., 8712 WARD)

2-FULL NAME Bessie Rose

(a) RESIDENCE NO. 2004 E. Chase ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

6a If married, widowed, or divorced HUSBAND of or) WIFE of William L. Rose

6 DATE OF BIRTH (month, day, and year) Sept. 27 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lebon Pa.
(State or country)

PARENTS

10 NAME OF FATHER Levi Tattnall

11 BIRTHPLACE OF FATHER (city or town) Lebon Pa
(State or country)

12 MAIDEN NAME OF MOTHER Mary Mundy

13 BIRTHPLACE OF MOTHER (city or town) Lebon Pa
(State or country)

14 Informant William L. Rose

(Address) 2004 E. Chase St.

15 Filed JUN 24 1930 HARRY JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22nd 1930

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1930, to June 22, 1930,

that I last saw h alive on June 22, 1930,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Int. Nephritis

(duration) 3 yrs. 3 mos dá.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. C. Slade, M. D.

, 19 (Address) 1430 E. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dale Lawn Cemetery

DATE OF BURIAL June 26 1930

20 UNDERTAKER Lilly & Geiler & Sc.

ADDRESS 403 S. Wolfe St

pec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58246

33 ✓ E 58246

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 N. Washington ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizebeth Rubin

(a) RESIDENCE NO. 126 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Rudolph Rubin

7 DATE OF BIRTH (month, day, and year) April 18 1909

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy.

10 NAME OF FATHER James Marsaleka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Agnes Wanicek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Rudolph Rubin

(Address) 126 N. Washington

15 Filed ....., 19.... ..... Registrar

24 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 21st, 1930, to June 24th, 1930, that I last saw h.. alive on June 23rd, 1930 and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

" Tuberculosis, Involving the Meninges & Intestines. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis?

(Signed) E. Gordon Wallace, M. D.

, 1930 (Address) Essex, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	June 26 1930
20 UNDERTAKER Fruit & Wachter 1406	ADDRESS Eastend

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58247

CERTIFICATE OF DEATH

129 E 58247

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1327 W. La Fayette St., 16-23 Ward)

2-FULL NAME Geo. Howe

(a) RESIDENCE NO. 1327 W Lafayette Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 22 - 1886

7 AGE: Years 44 | Months 10 | Days -1 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED: (a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Bethlehem

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Geo. Howe

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Eliza Forestey

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Ethel Bustey

(Address) 1327 W Lafayette

Filed JUN 24 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Sudden

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Intestinal Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. H. Leek, M. D.

Coroner

June 28 1930

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: June 26, 30

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1303 Eastern Ave.

Imperfect. See instruction on back of certificate.

spec.—1-30—M. & T.—250 Blks.

E 58248

E 58248 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No.) Calvert & Centre (Ward) 13-25

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H Gallagher

(a) RESIDENCE NO. 2818 Wood Brook Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Annie (Appel) Gallagher

6b DATE OF BIRTH (month, day, and year) Nov. 22, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	5	21	

8a OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector for City

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8b BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Emanuel Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Mullen Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Joseph Gallagher

(Address) 2818 Wood Brook Ave

15 Filed 6-24-1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-21-1930

17 I HEREBY CERTIFY, That I attended deceased from 6-18-30, 19..., to 6-21-30, 19..., that I last saw h— alive on 6-21-30, 19... P and that death occurred, on the date stated above, at 10-31 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Neck

(duration) yrs. 4 mos. ds.

Uremia

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6-20-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Wm Kindrick, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Govans

DATE OF BURIAL June 25 1930

20 UNDERTAKER Martin Fahey & Sons

ADDRESS 1827 N North Ave

Dominic Patti

71-001

58249

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58249

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (NO. ..... ST. 25 WARD)

2-FULL NAME Dominic Patti

(a) RESIDENCE NO. 1020 Eastern Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Jan 7 1889

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Ghostenolo Patti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Carmella Salonka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Linnie Patti (Address) 1020 Eastern Ave

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/22/30

17 I HEREBY CERTIFY, That I attended deceased from 6/20/30, 19..., to 6/22/30, 19..., that I last saw h. alive on 6/22/30, 19..., and that death occurred, on the date stated above, at 1:50 p. m.

The CAUSE OF DEATH* was as follows:

Pachymeningitis Haemorrhagica (Type not yet determined)

(duration) ... yrs. ... mos 14 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) David Jenne, M. D.

6/22/30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL June 25 1930

20 UNDERTAKER Dr. W. E. Doppelhe

ADDRESS 32 Lan

pec.—1-30—M. & T.—250 Blks.

238146
58250

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58250

49

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. James Novak ST. 2-4 WARD)

2-FULL NAME 202 S. Castle

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Frances

7 DATE OF BIRTH (month, day, and year) April 25-1877

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	1	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Andy Novak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 24 1930 HARRY [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24-1930

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1930, to June 24, 1930, that I last saw him alive on June 24, 1930, and that death occurred, on the date stated above, at 12 55 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis (duration) yrs. ½ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6-21-30

Was there an autopsy? no

What test confirmed diagnosis? Rectal examination Biopsy & Stain

(Signed) George B. Zinney M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem. | DATE OF BURIAL June 28 1930

20 UNDERTAKER M. W. & E. Dupp[illegible] Inc. | ADDRESS 32 [illegible]

spec.—2-29-28—L. F. S.—500 Bks.

Costello

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58251

CERTIFICATE OF DEATH

90 ✓ E 58251

1—PLACE OF DEATH

REGISTERED NO. 18-26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1002 W. Fayette ST. (WARD)

2—FULL NAME Mary Jane Costello

(a) RESIDENCE NO. 1002 W. Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of John T Costello

DATE OF BIRTH (month, day, and year) June 19, 1853

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	—	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER John McGovern

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER — McGarrity

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs. Jane Costello

(Address) 1002 W. Fayette St.

15 Filed ....., 19.... C. HARRISON JONES, M. D. Registrar

Per Rose

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1930.

17 I HEREBY CERTIFY, That I attended deceased from December 11, 1929, to June 22, 1930,

that I last saw h[illegible] alive on June 22, 1930

and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Senile cystitis, sclerosis and myocarditis

(duration) over a month yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry Coale, M. D.

6-24, 1930 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 25 1930
20 UNDERTAKER Vernon Keehner	ADDRESS 683 Holbrook

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58252

CERTIFICATE OF DEATH

E 58252

REGISTERED NO. 24-37 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. E. Clement St & B.& O R R. track St., Ward)

2-FULL NAME Joseph W. Dudley. Sr.

(a) RESIDENCE NO. 1528 Riverside Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. —mos. —ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, HUSBAND of (XXXXXXXXX) Anna M. Dudley.

6 DATE OF BIRTH (month, day, and year) June 4, 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	68	0	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Assistant foreman
(b) General nature of industry, business, or establishment in which employed (or employer) B.& O.R.R.Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Alexandria, Va.
(State or country)

PARENTS

10 NAME OF FATHER Joseph W. Dudley.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Minerva Mitchell.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Joseph W. Dudley. Jr. (son)
(Address) 1528 Riverside Ave.

15 Filed JUN 24 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardiat Insufficiency.
Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Leonhard, M. D.

6/23 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL 6/25 1930

20 UNDERTAKER I. Few McCully

ADDRESS 1306 E. Fort

Important. See instructions on back of certificate.

pec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58253

CERTIFICATE OF DEATH.

129 E 58253

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 1048 Argyle Ave St. 17-24 WARD)

2-FULL NAME George W. Goff

(a) RESIDENCE NO. 1048 Argyle Ave ST., WARD 17th
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Ruby Goff

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 54 | Months ✓ | Days ✓ | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Helps Builders

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Ruby Goff

(Address) 1048 Argyle Ave

Filed JUN 24 1930, 19 C. HAMPSON JONES, M. Registrar

By RMP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23-1930

17

I HEREBY CERTIFY, That I attended deceased from June 16th, 1930, to June 23, 1930, that I last saw him alive on June 22nd, 1930, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Nephritis & Endocarditis

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Unknown

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Jno A Cayer, M. D.

, 19 (Address) 1433 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Faber Cemetery

DATE OF BURIAL: June 26, 1930

20 UNDERTAKER: Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

1-30—M. & T.—100 B—50L

E 58254

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-06

E 58254

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Mulberry ST. 18-N WARD)

2-FULL NAME Baby Watkins

(a) RESIDENCE NO 1103 Mulberry ST., ... WARD .....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 23, 1930

7 AGE	Years	Months	Days	If LESS than 1 day 19 hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Watkins

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Cumberland

12 MAIDEN NAME OF MOTHER Henrietta Parrott

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) N. C.

14 Informant Mother
(Address) .....

15 [illegible] 1930 Reg. C. HAMPSON JONES, M. D. Registrar

Par. C.H.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. A. Woodcock, Coroner, M. D.

6/24 1930 (Address) 3601 Third St Brooklyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL June 24 1930

20 UNDERTAKER [illegible] Curtis R Williams — ADDRESS 922 N Schroeder St

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-007 ✓

E 58255

CERTIFICATE OF DEATH

E 58255

REGISTERED NO. 4567

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hosp ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Neal Dailey

(a) RESIDENCE NO. 2914 Ellicott Drive WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Marion Thomas

DATE OF BIRTH (month, day, and year) Sept 13 1893

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	9	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Saleswoman

(c) Name of employer K. Katz & Sons

BIRTHPLACE (city or town) Baltimore

(State or country) Md

10 NAME OF FATHER John A. Dailey

11 BIRTHPLACE OF FATHER (city or town) Frostburg

(State or country) Md

12 MAIDEN NAME OF MOTHER Virginia Evalt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md

14 Informant Louise M. Dailey

(Address) 2914 Ellicott Driveway

Filed JUL 4 1930, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22-30

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1930, to June 22, 1930, that I last saw him alive on June 22, 1930 and that death occurred, on the date stated above, at 2 35 P m.

The CAUSE OF DEATH* was as follows:

Ruptured Duodenal ulcer

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? yes gastro-enterostomy Date of 6/10/30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Arthur Rattenni, M. D.

6/22/1930 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 6/25-30

20 UNDERTAKER H. C. Brauning Sons

ADDRESS 1136 Pulaski Hwy

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 ✓

E 58256

E 58256

REGISTERED NO.

1—PLACE OF DEATH 3212

CITY OF BALTIMORE: (No. 3212 Inglewood Ave. 27-55 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Knowles

(a) RESIDENCE NO. 3212 Inglewood Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Wht	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Knowles

DATE OF BIRTH (month, day, and year) March 26/1852

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	2	26 28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam fitter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 060

(c) Name of employer

BIRTHPLACE (city or town) Manchester

(State or country) Eng.

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Manch.

(State or country) Eng.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Manch.

(State or country) Eng

14 Informant Mrs Thomas Knowles

(Address) 3212 Inglewood Ave

15 [illegible] 19 Registrar

2 4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22/30

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 22, 1930

that I last saw h. alive on June 21, 1930

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Failing heart, mental degradation

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) E. Schmeck, M. D.

6/22, 1930 (Address) 1665 N. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL June 25, 1930

20 UNDERTAKER Wm. J. Tickner & Sons ADDRESS N. & Pa

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58257

E 58257

CERTIFICATE OF DEATH

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 810 Burgundy St. 7-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Zinnel

(a) RESIDENCE NO. 810 Burgundy St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S. if of foreign birth? / yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Zinnell

6 DATE OF BIRTH (month, day, and year): January 22-1835

7 AGE: Years 95 Months 5 Days 1

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs. Lena Winters

(Address) 810 Burgundy St.

15 Filed: C. HAMPSON JONES, M. D. Registrar

By: ASST

4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23 19 30

17 I HEREBY CERTIFY, That I attended deceased from April 19 29 to June 23 19 30

that I last saw him alive on June 22 19 30

and that death occurred, on the date stated above, at 4:15 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. Headowsky M. D.

(Address) 642 Washington Blvd 6/23 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. Date of Burial June 25 1930

UNDERTAKER: Wm. J. Tuckwell Sons

ADDRESS N. Y. Pa

very important. See instructions on back of certificate.

pec.—1-30—M. & T.—250 Blks

E 58258 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58258

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 5-8 WARD)

CITY OF BALTIMORE: (NO. George Watts ST., WARD

2-FULL NAME 713 E. Fayette (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. (Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

7 DATE OF BIRTH (month, day, and year) Oct. 20, 1887

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Bot

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Watts

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Marjorie Butler

13 BIRTHPLACE OF MOTHER (city or town) Penna. (State or country)

14 Informant Records of (Address) B. C. H.

Filed 6-24-1930 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23-30

17 I HEREBY CERTIFY, That I attended deceased from 6-14-30, 19..., to 6-23-30, 19..., that I last saw him alive on 6-23-30, 19..., and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) yrs. 1 mos da.

CONTRIBUTORY (Secondary) Alcoholism, chronic

(duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? History, Exam. Autopsy

(Signed) Paul Padgett, M. D.

6-24, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delta Pa

DATE OF BURIAL June 26 1930

20 UNDERTAKER D. J. Tuckena & Son

ADDRESS N. Calvert

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 58259

E 58259

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 22-31 WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Louis Brown

(a) RESIDENCE NO. 829 Bevan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

Unknown

7 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Broker McDurman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Anna Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of (Address) Balto. City Hospitals

15 6-4 1930 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-20-30

17 I HEREBY CERTIFY, That I attended deceased from 5-26-29, 19..., to 6-20-30, 19...,

that I last saw him alive on 6-20-30, 19...,

and that death occurred, on the date stated above, at 8:20 A. m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta & aortic insufficiency and aneurysm.

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. 14 mos. ds.

18 Where was disease contracted if not at place of death? L. Howard S. Hospital.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray; Wasserman; exam

(Signed) Paul Padget. M. D.

6-23, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUN 24 1930 19

20 UNDERTAKER Samuel C. Hemsley

ADDRESS

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58260 E 58260

CERTIFICATE OF DEATH

47

16-27

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 Harlem Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellye R. Wooden

(a) RESIDENCE NO. 1725 Harlem Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 11 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of George C. Wooden

DATE OF BIRTH (month, day, and year) July 4 1879

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	11	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER John Roberts

11 BIRTHPLACE OF FATHER (city or town) England (State or country)

12 MAIDEN NAME OF MOTHER Margaret Carey

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mr. Wooden

(Address) 1725 Harlem Ave.

15 Filed ..... 19 ..... Registrar

6 24 1930 RRR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1930, to June 24, 1930, that I last saw her alive on June 23, 1930 and that death occurred, on the date stated above, at 1.30 P.m.

The CAUSE OF DEATH* was as follows:

Cacinoma of breast with metastases Liver and stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of About Dec. 1929

Was there an autopsy? —

What test confirmed diagnosis? Laboratory findings

(Signed) John B. Gosford, M. D.

6/24 1930 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 6/28 1930

20 UNDERTAKER J. Lew McCully

ADDRESS 1305 Fayt.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58261

CERTIFICATE OF DEATH

185 E 58261

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 47 (Ward)

2-FULL NAME John R Ferguson

(a) RESIDENCE NO. 1546 Gay St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 20 1873

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Ky.

PARENTS

10 NAME OF FATHER Jos Ferguson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ky?

12 MAIDEN NAME OF MOTHER Kate ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ky.

14 Informant John R. Ferguson
(Address) 1546 Gay St. Baltimore

15 Filed ... G. HAMPSON JONES, M. D. Registrar
4 1930 By ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the date stated above.

The CAUSE OF DEATH was as follows:

Diabetes Mellitus
Acc Fall in Hospital on floor
Fodrum Left Hip
(duration) yrs. 6 mos. 23 ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no. Date of —

Was there an autopsy? no History

What test confirmed diagnosis? —

(Signed) C. C. Slade, M. D.

June 23 (Address) 1436 Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem.

DATE OF BURIAL 6/25 1930

20 UNDERTAKER Daniel Easton

ADDRESS 916 Ga. Ave.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 E 58262

REGISTERED NO. E 58262

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 619 S Dallas St., 3-4 (Ward)

2-FULL NAME John Arendt

(a) RESIDENCE NO. 619 S Dallas St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 8 mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 22 1877

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	52	8	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant P. K. McCarty
(Address) 1209 Woodbine Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) 1 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirms diagnosis?

(Signed) G. H. Dades, M. D.

. 19 (Address) 1416 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	June 25 1930
20 UNDERTAKER John Moverel	ADDRESS 708 E Chester

Spec.—6-9-19—H. F. Co.—1000 Blks.

58263

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 58263

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5324 Dennison ST. (or) 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Evans

(a) RESIDENCE. No. 1802 Laurentia AVE ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) [illegible] 1865

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Transfer Co

(b) General nature of industry, business, or establishment in which employed (or employer) Business

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER Emma [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Emma Callis

Address 5324 Dennison Ave

Filed . 19 Registrar

25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23 1930

17 I HEREBY CERTIFY, That I attended deceased from June 19 . 1930 . to June 23 . 1930 .

that I last saw him alive on June 23 . 1930 .

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's disease.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Objective & urinary Symptoms

(Signed) G. W. Buckley, M. D.

, 19 (Address) 3337 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 26 1930

20 UNDERTAKER Geo. H. Trader ADDRESS 1027 Druid Hill

HANDSON SHOP

Spec.—1-10-21—M&T—1500 Bks.

Infant Edgar

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58264

CERTIFICATE OF DEATH.

25-75 (161-001)

REGISTERED NO. E 58264

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3524 7th St (ST.) (WARD)

2-FULL NAME Twins

(a) RESIDENCE NO. 3524 7th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6-16-30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			6 5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) 3524 7th St Brooklyn Balto md.
(State or country)

PARENTS

10 NAME OF FATHER Theodore Edgar

11 BIRTHPLACE OF FATHER (city or town) Boston
(State or country) Mass

12 MAIDEN NAME OF MOTHER Ethel Porter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New York

14 Informant Ethel Edgar
(Address) 3524 7th St Brooklyn Md

15 Filed JUN 22 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-21 1930

17 I HEREBY CERTIFY, That I attended deceased from 6/16, 1930, to 6/21, 1930, that I last saw her alive on 6/21, 1930, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos ds. —

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) J. L. Hamilton, M. D.

6/22, 1930 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Lot Hopkins

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58265

E 58265

CERTIFICATE OF DEATH

REGISTERED NO. 74

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1044 N. Mount ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary Kovas

(a) RESIDENCE NO. 1044 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Ceretani Kovas

DATE OF BIRTH (month, day, and year): 1870-

AGE: Years 55 | Months — | Days — | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Lancaster Co. Penn

10 NAME OF FATHER: Waylan Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

Informant: Mrs. Eva DeBey

(Address): 1044 N. Mount St

Filed 6-25 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1930

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1930 to June 22, 1930

that I last saw her alive on June 22, 1930

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. E. Bell M. D.

6-24 1930 (Address) 113 Glenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: 6-25 1930

20 UNDERTAKER: Wm. H. Case Son

ADDRESS: 1400 Mosher

pec.—1-30—M. & T.—250 Bks.

E 58266

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58266

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1608 Harford Ave ST. 9-18 WARD)

2-FULL NAME Charles D. Hirsch

(a) RESIDENCE NO. 1608 Harford Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Nellie Hirsch

7 DATE OF BIRTH (month, day, and year) 3-28-1866

AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	64	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John M. Hirsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas. D. Hirsch
(Address) 1608 Harford Ave

Filed ... 5-1930 ... 19 ... HARRY C. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 8 - 1930, to June 28 - 1930,

that I last saw him alive on June 23 - 1930,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) ? yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) L. A. C. Parker, M. D.

6/25, 1930 (Address) 1114 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 6/26/30

20 UNDERTAKER Mary T. Ruth

ADDRESS 1735 Harford Ave

E 58267

HEALTH DEPARTMENT--CITY OF BALTIMORE / E 58267

CERTIFICATE OF DEATH

90 REGISTERED NO. C

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

E 58267

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1149 N. Calhoun ST.) 16-23 (WARD)

2 FULL NAME Theodrick Lewis St: 50 yrs. mos. ds.)

(Residence in Baltimore: No. 1149 N. Calhoun

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: O. K. (Month) O. K. (Day) O. K; 1880 (Year)

7 AGE: 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Virginia

PARENTS

10 NAME OF FATHER: Peter Lewis

11 BIRTHPLACE OF FATHER (State or country): Virginia

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (State or country): Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Lewis

(Address) 1149 N. Calhoun St

15 HAMPSON JONES, M. D.

Registrar

JUN 25 1930 191

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 24 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June-5-, 1930, to June-24-1930, that I saw h[illegible] alive on June-24-1930, and that death occurred, on the date stated above, at 12 05 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(Duration) not known yrs. mos. ds.

Contributory (SECONDARY) Acute Cystitis (Duration) about 10 days yrs. mos. ds.

no autopsy no operation

(Signed) 6/25/30, 191 (Address) Herman Study M. D. 2404 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: North Thumberland Co. Va. DATE OF BURIAL: 6-25-1930

20 UNDERTAKER: Jas. H. Holland ADDRESS: 1631 Druid Hill

This is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 58268 HEALTH DEPARTMENT—CITY OF BALTIMORE 91-002 E 58268

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 Cathedral St. 11-24 WARD)

2-FULL NAME Josephine A. Kellogg Fraser

(a) RESIDENCE NO. 609 Cathedral St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of the late Gilbert Fraser

DATE OF BIRTH (month, day, and year) Jan 11th 1850

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	80	6	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

BIRTHPLACE (city or town) Stonington
(State or country) Conn.

10 NAME OF FATHER Henry A. Kellogg

11 BIRTHPLACE OF FATHER (city or town) Mystic
(State or country) Conn.

12 MAIDEN NAME OF MOTHER Delia Eldridge

13 BIRTHPLACE OF MOTHER (city or town) Stonington
(State or country) Conn

Informant daughter, Delia A. F. Pearsman
(Address) 609 Cathedral St

Filed 5-1930 ..., 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 21st, 1926, to June 23rd, 1930,

that I last saw her alive on June 23rd, 1930,

and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 7 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Thomas L. Shearer, M. D.

, 19 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL June 25 1930

UNDERTAKER Harry A. Jenkins Sons — ADDRESS McCulloh & Orchard Sts

Cor.—10-10-29—A Co.—100 Bks.

E 58269

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1827 E 58269

REGISTERED NO. 23-34

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Spring Gardens, N of Hanover St., Ward)

2-FULL NAME William A. Rosky.

(a) RESIDENCE NO. 1444 Light St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Divorced.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine Rosky.

6 DATE OF BIRTH (month, day, and year) June 16, 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	29	0	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bar keeper.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William Rosky.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Lena Yesker.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Lena Rosky. (mother)
(Address) 1444 Light St.

Filed JUN 25 1930 H. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental drowning while in bathing

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Einhard, M. D.

6/24 1930 (Address) 1015 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Holy Cross Cem. a.a.

DATE OF BURIAL June 26 1930

UNDERTAKER A. Howard Evans

ADDRESS 38 E. Fat ave

Dec.—1-30—M. & T.—250 Blks.

Harrison R. Rathell Sr

E 58270 HEALTH DEPARTMENT—CITY OF BALTIMORE 12 E 58270

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1521 Hanover St. 23-24 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison R. Rathell.

(a) RESIDENCE NO. 1521 Hanover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 9 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Rathell.

DATE OF BIRTH (month, day, and year) Sept. 17, 1873.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56,	9,	6.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman, Sun Office.

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

BIRTHPLACE (city or town) Balto. Md.
(State or country)

10 NAME OF FATHER Joseph Rathell.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Hodges.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mary E. Rathell.
(Address) 1521 Hanover St.

15 Filed N 25 1930, 19 C. HARRISON JONES, M. D. *Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1— 1930, to June 23d 1930,
that I last saw h— alive on June 23d 1930,
and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hutzler, M. D.

, 19 (Address) 1540 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL June 26 1930

20 UNDERTAKER C. Howard Evans ADDRESS 38 E. Fayette and

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58271

CERTIFICATE OF DEATH.

E 58271

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Fildelphia + Caton Avenues ST. 25 N WARD)

2-FULL NAME Edmund Harold

(a) RESIDENCE NO. 2 2nd & Washington Sts ST., Lansdowne WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
7 Weeks	0	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore md

PARENTS

10 NAME OF FATHER John. Harold

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Belt Co md

12 MAIDEN NAME OF MOTHER Emma Bendanzer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Belt Co md

14 Informant John Harold
(Address) 2nd + Washington Sts

15 Filed JUN 25 1930 16 H. [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1930

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to June 25 1930,
that I last saw h alive on June 25, 1930,
and that death occurred, on the date stated above, at 3 15 a m. Standard time
The CAUSE OF DEATH* was as follows:
Pyloric Stenosis Congenital

(duration) yrs. 1 mos 20 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? yes Date of June 23-30
Was there an autopsy? No
What test confirmed diagnosis? Operation

(Signed) Ernest Spencer Jr., M. D.
19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	June 26 1930
20 UNDERTAKER Jas Joesden's Son	ADDRESS 2173 Pres.

Spec.—1-30—M. & T.—250 Bks.

E 58272

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001

E 58272

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3305 Eastern ave ST. 7th WARD)

2-FULL NAME Morris Mankowitz

(a) RESIDENCE NO. 3305 Eastern ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 40 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Ida

DATE OF BIRTH (month, day, and year) May 3 1881

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	1	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) ..... O.W.

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Mankowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Ida Mankowitz
(Address) 3305 Eastern ave

15 Filed JUN 25 1930 C. HARRISON JONES, M. D. Registrar
Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23/30

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to June 23, 1930, that I last saw him alive on June 23, 1930, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of June 20/30

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Adolph Falk, M. D.

6/24/30 (Address) 2028 E. Monument ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cmt

DATE OF BURIAL 6/25 1930

20 UNDERTAKER Chas. Levinson & Bro

ADDRESS 1127 E Balto st

Spec.—2-29-28—L. F. S.—500 Blks.

58273

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00 E 58273

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 532 n Central ST. 58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charlotte A Jackson

(a) RESIDENCE NO. 532 n Central Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 6 mos. 20 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX F | 4 COLOR OR RACE C | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Noah Jackson

DATE OF BIRTH (month, day, and year) Dec 2-72

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	6	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(r) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Perry Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lizzie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Sadie Russell

(Address) 532 n Central Ave

Filed JUN 25 1930 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22-30

17 I HEREBY CERTIFY, That I attended deceased from June 20 19 ... to June 22 1930, that I last saw h alive on June 22 1930 and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) ... yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) No

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ... M. D.

June 23 19 30 (Address) 508 n ... St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL national cemetery — DATE OF BURIAL June 25 19 30

20 UNDERTAKER Edward Boyer — ADDRESS 169 / orleans st

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 58274

E 58274

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST.

2-FULL NAME Edward Copeland

(a) RESIDENCE NO. 436 Somerset st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Copeland

DATE OF BIRTH (month, day, and year) 1900 ?

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30 ?			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Portsmouth

(State or country) Virginia

10 NAME OF FATHER John Copeland

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

Informant Hospital Records

(Address)

Filed JUN 25 1930. H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1930

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to June 23, 1930,

that I last saw him alive on June 23, 1930,

and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Chas Strauch Jr M.D.

6-23-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Evergreen Cemetery

DATE OF BURIAL 6-26 1930

20 UNDERTAKER Mrs Edna G. Bailey

ADDRESS 1321 Jefferson St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58275 — 90 — E 58275

E 58275
1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 3703 Lynchester Rd. ST. 15 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clayton Stutsman,

(a) RESIDENCE NO. 3703 Lynchester Rd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Catherine Stutsman

6 DATE OF BIRTH (month, day, and year): May 2/1859

7 AGE: Years 71 Months 3 Days 22 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired restaurant

(b) General nature of industry, business, or establishment in which employed (or employer): keeper 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Stutsman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Hoberstorf

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Martha F. Singer
(Address) 3703 Lynchester Road

15 Filed 6 25 1930 G. MAURICE JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1930 to June 24, 1930, that I last saw him alive on June 24, 1930, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (duration) yrs. mos 1 ds.

Chronic Myocarditis

CONTRIBUTORY (Secondary) (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Stanard, M. D.

6/27, 1930 (Address) 1901 Griffis Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: June 26 1930

20 UNDERTAKER: Harry H. Sinnacoe — ADDRESS: 4204 Ridgewood Ave

pcc.—1-30—M. & T.—250 Bks.

E 58276 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58276

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 Clifton Ave ST. 9-45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Fredrick Fischer

(a) RESIDENCE NO. 1610 Clifton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) July 15, 1900

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	11	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Martin Fischer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eleonore Fobermann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Martin Fischer
(Address) 1610 Clifton Ave

15 FILED 2-5 1930 19 H. [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24-1930

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1930, to June 24, 1930, that I last saw him alive on June 24, 1930, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute pneumonia Bilateral

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) [illegible] M. D.

(Address) 2147 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL June 27 1930

20 UNDERTAKER John Ulrich — ADDRESS 2008 Orleans

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-602

E 58277

58277.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. In front of 10 E. Camden St. St. 8-16 Ward)

2-FULL NAME Theodore S. Seward.

(a) RESIDENCE NO. 1688 N. Gay St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 0 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Kate A. Seward.

6 DATE OF BIRTH (month, day, and year) May 28, 1869

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	61	0	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Commission Merchant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Timothy Seward.

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Kate A. Seward. (wife)
(Address) 1688 N. Gay St.

15 Filed JUN 25 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

6/24 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 6/27/30

ADDRESS

20 UNDERTAKER Mary T. Puth, 1935 Hanover

Page

Spec.—1-30—M. & T.—250 Bks.

E 58278

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58278

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Caroline & Oliver St (Ward) 16-22

2-FULL NAME Earl Walter Dorsey

(a) RESIDENCE NO. 815 N. Fulton Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~, (write the word): Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 24 1905

7 AGE — Years: 25 — Months: 3 — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Tope Bakery

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Wm T. Dorsey

11 BIRTHPLACE OF FATHER (city or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Sadie King

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant Wm T. Dorsey

(Address) 1723 E. Lafayette Ave

Filed 6-25-1930 C. HAMPSON JONES, M. D. Registrar

By HKB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-24-30

17 I HEREBY CERTIFY, That I attended deceased from 6-20, 1930, to 6-24, 1930,

that I last saw h. alive on 6-24, 1930,

and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder (Cervix)

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) X W. Whedbee M. D.

, 19 (Address) 1 E Preston St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: June 26 1930

20 UNDERTAKER: Putnam & Sons — ADDRESS: 1923 W. Lafayette Ave

Spec.—1-30—M. & T.—250 Bks

E 58279

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58279

CERTIFICATE OF DEATH.

REGISTERED NO. 100

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 21-24 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Wortman

(a) RESIDENCE NO. 847 Reinhardt St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa A.

6b DATE OF BIRTH (month, day, and year) Oct. 3, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45	36	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Benjamin

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed ....., 19..... G. HAMPSON JONES, M. D.

6 25 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-24-30

17 I HEREBY CERTIFY, That I attended deceased from 6-6-30, 19....., to 6-24-30, 19.....,

that I last saw him alive on 6-24-30, 19.....,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Alcoholism, chronic + acute; Korsakow Psychosis.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1. Home. 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy. History.

(Signed) Paul Paget, M. D.

6-25 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem

DATE OF BURIAL 6/27 1930

20 UNDERTAKER Robert Brook Son

ADDRESS Baltimore

0—M. & T.—100 B—50L

E 58230

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

199 E 58280

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp S. 12-19 WARD)

2-FULL NAME Mary A Flaherty

(a) RESIDENCE NO 414 E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 12

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	9	20	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clk
(b) General nature of industry, business, or establishment in which employed (or employer) Ret
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Thos Flaherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Anna McDonnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary A Flaherty

(Address) 414 E Lanvale St

15 Filed ..... 192 ... Registrar

C. HARRISON JONES, M.

5 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Base of skull in rumble seat of auto it collided with car and woman auto throwing her out & trouser leg

Cardiac Chest (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Shock Fract Base of skull & Side

Edema Lung (duration) yrs. mos. ds.

(A) Where was disease contracted if not at place of death? Preston & Lanvale

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & X Ray

(Signed) L. J. Frame, M. D. Coroner

(Address) 1939 W. Eldorado

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL June 26 1930

20 UNDERTAKER Mary W Woodfield

ADDRESS 501 E 22nd

0—M. & T.—100 E—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58281

CERTIFICATE OF DEATH

199 E 58281

REGISTERED NO. .....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen. Hosp ST. 9-19 (WARD)

2-FULL NAME Ann E. Carat

(a) RESIDENCE NO 1800 Barclay St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 24 1913

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	7	27	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) 509
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Harry B. Carey

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Walle

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs E Carey
(Address) 1800 Barclay St

Filed 5-1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
While riding in the rumble seat of a car it overturned when it collided with a car and another auto crashing into them

same (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) ..... yrs. 4 mos. ..... ds.

18 Where was disease contracted if not at place of death? Preston & Linden

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Frame, M. D.
Coroner

6/25 1930 (Address) 2934 W. Eldon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL June 26 1930

20 UNDERTAKER Mary M. Wedefeld — ADDRESS 501 E 22

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58282

CERTIFICATE OF DEATH

90 E 58232

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4707 Roland Ave Ward 27-53)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Benson Head

(a) RESIDENCE NO. 4707 Roland Ave St. ✓ Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ✓ mos. ✓ ds. How long in U. S. if of foreign birth 25 yrs. about ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mrs Blanche V. McPherson Head

6 DATE OF BIRTH (month, day, and year) Aug 19. 1865

7 AGE	Years	Months	Days
	64	10	6

IF LESS than 1 day ___ hrs. or ___ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Policeman

(b) General nature of indostry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Hamilton

(State or country) Bermuda

PARENTS

10 NAME OF FATHER Wm. Benson Head

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Bermuda

12 MAIDEN NAME OF MOTHER Julia A. Roberts

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Bermuda

14 Informant Blanche V. McPherson Head (Address) 4707 Roland Ave.

15 Filed 6/27 1930 C. HAMPSON JONES, M. D. Registrar

5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25—1930.

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1930, to June 25, 1930, that I last saw ~~him~~ alive on June 24, 1930, and that death occurred, on the date stated above, at 7.15 a.m. standard

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) ✓ yrs. 7 mos. ✓ ds.

CONTRIBUTORY (Secondary) Coma - Auto intoxication

(duration) ✓ yrs. ✓ mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) George E. Hamman, M. D.

6/25 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial 6/27 1930

20 UNDERTAKER Henry W. Spears and Son — ADDRESS 805 W. Calvert

Very important. See instructions on back of certificate.

pec.—1-30—M. & T.—250 Bks.

E 58283 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58283

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1128 Ridgely St. (St.) 21-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma V. Sheldon

(a) RESIDENCE NO. 1128 Ridgely St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 8 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Late James E. Sheldon

DATE OF BIRTH (month, day, and year) Oct. 5, 1858.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	8	19	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Birkhead

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) William Sheldon 1128 Ridgely St.

15 6-25 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/24/30

17 I HEREBY CERTIFY That I attended deceased from May, 1930, to June, 1930

that I last saw her alive on June 24 1930,

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cause of Eye

Tonsilitis

(duration) yrs. 6 mos da.

CONTRIBUTORY (Secondary) cardiac insufficiency

(duration) yrs. mos. 12 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Maryland Hospital Laboratory

(Signed) Mathew Brown, M. D.

6-27, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 6/27/30,

20 UNDERTAKER Harry N. Witzke, 410 ADDRESS Edmondson Ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58284

CERTIFICATE OF DEATH

E 58284

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mt Hope Hospital St., 8-72 Ward)

2-FULL NAME James Mansfield

(a) RESIDENCE NO. Salem Mass St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) June 6 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	49	—	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) Consumption Factory
(c) Name of employer

9 BIRTHPLACE (City or town) Salem (State or country) Mass

PARENTS

10 NAME OF FATHER Thos Mansfield

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Johanna Mahoney

13 BIRTHPLACE OF MOTHER (city or town) Lawrence Mass (State or country)

14 Informant Mt Hope Asylum Reminal (Address) Mt Hope

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry) find that said deceased came to ... death on the date stated above.

The CAUSE OF DEATH* was as follows:

Suicide Lacerated throat

Razor. Sudden

(duration) ... yrs. ... mos. ...

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Mt Hope Asylum

Did an operation precede death? No Date ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) ... M. D.

(Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salem, Mass — DATE OF BURIAL June 28/30

20 UNDERTAKER Stewart Mooney Co. 108-10 Northern — ADDRESS

pec.—1-30—M. & T.—250 Bks.

E 58285 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58285

86-002

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 18-66 WARD)

2-FULL NAME Charlotte Louise Mitten

(a) RESIDENCE NO. 719 Winans Way ST., ... WARD .....
(Usual place of abode) Hunting Ridge Md. (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? 7 yrs. 11 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of Single

DATE OF BIRTH (month, day, and year) July 22 1922

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	11	2	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) School Girl

(c) Name of employer none

8 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER C. Emory Mitten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Helen L. Whitby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (C. Emory Mitten - Father)
(Address) 719 Winans Way

15 Filed 2 5 1930, 19 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1930, to June 24, 1930, that I last saw her alive on June 24, 1930, and that death occurred, on the date stated above, at 2:20 A.m.

The CAUSE OF DEATH* was as follows:

Septicaemia Streptococcus hemolyticus

(duration) ..... yrs. ..... mos 26 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5/2/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical and laboratory

(Signed) Samuel T. Nelson, M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 26 '30
20 UNDERTAKER	ADDRESS
Stewart & Mowen Co.	108 W. North Ave.

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58286

CERTIFICATE OF DEATH

57

E 58286

1—PLACE OF DEATH

REGISTERED NO. 15-60

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 2428 Forest Park Ave. ST.) (WARD)

2—FULL NAME Mary E. Moran

(a) RESIDENCE NO. 2428 Forest Park Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
HUSBAND of (or) WIFE of Richard J. Moran

DATE OF BIRTH (month, day, and year) March 19, 1872

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	3	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Basil Wallace

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Louise Greenwald

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

Informant Mr. Clarence J. Moran

(Address) 2428 Forest Park Ave.

25 1930 G. HAMPSON JONES, M. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to June 24, 1930, that I last saw her alive on June 24, 1930 and that death occurred, on the date stated above, at 12.35 P. m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus from History about

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical and Laboratory

(Signed) Walter S. Tublett, M. D.

June 24, 1930 (Address) 2220 Garrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Family Cemetery

20 UNDERTAKER Harrisonville

Joseph D Cook

DATE OF BURIAL

June 27 1930

ADDRESS 1003 West Baltimore St.

cc.—1-30—M. & T.—250 Bks.

E 58287 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58287.

74-04

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 4901 Roland ave ST.) 13-52 (WARD)

2-FULL NAME Bettie G. Bell

(a) RESIDENCE NO. 4901 Roland ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	widow

If married, widowed, or divorced
HUSBAND of
(or) WIFE of John C. Bell

DATE OF BIRTH (month, day, and year) Oct 30 1840

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	89	7	25	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work [illegible]
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

BIRTHPLACE (city or town) Harford Co.
(State or country) Md

10 NAME OF FATHER Benj. Gore

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Temperance Euler

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Rosa B. Wasche
(Address) 4901 Roland ave

15 Filed 6/25 1930 Registrar C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24-1930

17 I HEREBY CERTIFY That I attended deceased from June 12 1930, to June 24 1930, that I last saw h[illegible] alive on June 24 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Right Hemiplegia
(duration) ... yrs. ... mos ... ds.
CONTRIBUTORY (Secondary) Senile Arteriosclerosis
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Paralysis
Signed M. Tilson Finley, M. D.
19 30 (Address) 4822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem
UNDERTAKER J. Thomas Burch Co.
ADDRESS Eutaw Pl

DATE OF BURIAL June 26 1930

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58288

E 58288

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 12-49 WARD)

2-FULL NAME Mrs. Elizabeth Heald

(a) RESIDENCE NO. 3707 N. Charles ST., ... WARD C III
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of John M Duncan Heald

DATE OF BIRTH (month, day, and year) (1852)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78.			

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Art-Army wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER William H Armitage
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md
12 MAIDEN NAME OF MOTHER Eliza Anderson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr Edw E Heald
(Address) Same

15 Filed June 25 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1930, to June 25, 1930,
that I last saw her alive on June 24, 1930,
and that death occurred, on the date stated above, at 12:55 A m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(duration) ? yrs. mos ds (Brown)

CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. 36 hrs

18 Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of June 21, 1930
Was there an autopsy? No
What test confirmed diagnosis? Microscopic & X Ray
(Signed) Emma B Dolland, M D:
, 19 (Address) Church Home & Infr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem
UNDERTAKER John Ohnitsel & Son

DATE OF BURIAL June 26 1930
ADDRESS 1911 Eutaw Pl

...ec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58289

CERTIFICATE OF DEATH

X 179 E 58289

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Md Gen Hosp 10-37 ST., ... WARD)

2—FULL NAME Charles E Sliver

(a) RESIDENCE NO. 308 Oldham ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. — ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	M

If married, widowed, or divorced HUSBAND of (or) WIFE of Margret I Sliver

DATE OF BIRTH (month, day, and year) 2/30/1907

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	2	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balt. Steel Co.

BIRTHPLACE (city or town) (State or country) West Brownsville Pa

10 NAME OF FATHER Jas H Sliver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Dora Shearer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant .....

(Address) Hospital Records

Filed 5-1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25-30

17 I HEREBY CERTIFY, That I attended deceased from 6-24-30 19.... to 6-25-30 19....,

that I last saw h... alive on 6-25-30, 19....

and that death occurred, on the date stated above, at 1 15 a.m.

The CAUSE OF DEATH* was as follows:

1-2-3 Burns

Burns (over)

Erysipelas

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Toxemia of Pregnancy

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Spurrier Dorsey Hosp

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno M Cunningham, M. D.

....., 19.... (Address) 1 E Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Freeport Pa. Via Conn RR

DATE OF BURIAL June 25 1930

UNDERTAKER John F Denny

ADDRESS 715 Light St

Spec.—1-30—M. & T.—250 Bks.

E 58290 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58290

X 145-001

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Caroline St. WARD 5)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Coulby

(a) RESIDENCE NO. 5312 Merrello ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 wks. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced
HUSBAND of) WIFE of Edgar M. Coulby

DATE OF BIRTH (month, day, and year) ? ? ?

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 24			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Wm H Sims

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

PARENTS

14 Informant Joseph M. Coulby
(Address) Walbrook Maryland

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25-30

17 I HEREBY CERTIFY, That I attended deceased from 6-15-30, 19..., to 6-25-30, 19..., that I last saw h 4 alive on 6-25-30, 19..., and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Lobulitis & Obstruction
Peritonitis
(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Pregnancy & Influenza
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6/15/30 & 6/19/30

Was there an autopsy? No (over)

What test confirmed diagnosis? Operation

(Signed) H B Hendrix, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bellalton Md

DATE OF BURIAL 6/26/1930

20 UNDERTAKER Williams Cook

ADDRESS 1217 St Paul

C. HAMPSON JONES, M. D.

spec.—1-30—M. & T.—250 Bks.

E 58291

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58291

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH South Baltimore General Hospital

CITY OF BALTIMORE, No. ST. (or Hosp.)

2-FULL NAME Mrs. Mary Holzman

(a) RESIDENCE No. 1217 Bluecoe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of William Holzman

DATE OF BIRTH (month, day, and year) March 5, 1885

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	3	19	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

8 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William Holzman

(Address) 1217 Bluecoe St

Filed 6-25-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-24-30

17 I HEREBY CERTIFY, That I attended deceased from 6-17-30, 19..., to 6-24-30, 19...;

that I last saw her alive on 6-24-30, 19...;

and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. mos 1 da.

CONTRIBUTORY (Secondary) Cardio-vascular Renal Disease (duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph Lobstein, M. D.

, 19 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 6/27 1930

20 UNDERTAKER Freeman Cook

ADDRESS 1217 St Paul

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58292

CERTIFICATE OF DEATH

E 58292

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3564 Pork St. 13 57 Ward

2-FULL NAME Clara Grace Hare

(a) RESIDENCE NO. 3564 Pork St., 43 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H

6 DATE OF BIRTH (month, day, and year) 2-13- 1863

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	67	3	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER George Peffer

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Amanda Wallenz

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Thomas Hare
(Address) 2724 Dunmore Rd

15 Filed 5 1930 C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

6/25 1930 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL June 26 1930

20 UNDERTAKER Brownell Sons

ADDRESS 3615 Chestnut Ave

Important: See instructions on back of certificate

pec.—1-30—M. & T.—250 Bks

E 58293 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58293

CERTIFICATE OF DEATH

113

REGISTERED NO.

1-PLACE OF DEATH Union Mem. Hosp. 21-29 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Bowers ST. WARD)

2-FULL NAME Della Bowers

(a) RESIDENCE NO. 710 West Hamberg ST., Baltimore Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) April 23, 1930

AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
0		2	1	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work dependent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Bowers

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Houston

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Wm Bowers (Address) 710 W. Hamberg St.

15 Filed 6-5-1930 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 10th, 1930, to June 24, 1930, that I last saw her alive on June 24, 1930, and that death occurred, on the date stated above, at 11:50 p.m. D. S.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. D. Fiske M. D.

June 24 1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western DATE OF BURIAL 6/26 1930

20 UNDERTAKER Frank A. Kole ADDRESS 1200 W Lombard St.

Dec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58294

CERTIFICATE OF DEATH

31 E 58294

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 S. Milton Ave ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Aniela Chmiel

(a) RESIDENCE NO. 605 S. Milton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of John Chmiel

DATE OF BIRTH (month, day, and year) Nov. 28 1893

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	6	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Steve Dul

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Dul

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Chmiel

(Address) 605 S. Milton Ave

15 Filed ..., 19 ... C. HAMPSON JONES, M. D. Registrar

2 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1930

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930 to June 23, 1930

that I last saw her alive on June 23, 1930

and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? P. S & S.

(Signed) John J. Kriegs M. D.

, 19 (Address) 2627 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cemetery	6-27 19 30
20 UNDERTAKER	ADDRESS
Wm. H. Weber 101	Same

Spec.—1-30—M. & T.—250 Bks.

25-3874 58295 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58295

CERTIFICATE OF DEATH. X 71-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 7-9 WARD)

2-FULL NAME Walter Moore

(a) RESIDENCE NO. Birmingham Ala ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Mary

DATE OF BIRTH (month, day, and year) May 2-1860

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mine Operator

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ala.

PARENTS

10 NAME OF FATHER Joseph Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ala

12 MAIDEN NAME OF MOTHER Mary Loveland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ala

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 26 1930 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25-1930

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to June 25, 1930, that I last saw him alive on June 25, 1930, and that death occurred, on the date stated above, at 6 55 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary meningitis interna

(duration) 14 yrs. mos ds.

CONTRIBUTORY (Secondary) Operation infection

Meningitis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-14-30 (Removal of Blood Clot)

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray

(Signed) C. H. Buffington, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Birmingham Ala DATE OF BURIAL June 27 19 30

20 UNDERTAKER Geo. D. Whitehead Sons ADDRESS Place

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

58296

CERTIFICATE OF DEATH

143-001

E 58296

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1519 N.Spring ST. 9-17 (WARD)

2-FULL NAME Anna C. Hagner

(a) RESIDENCE NO 1519 N. Spring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Hagner

6 DATE OF BIRTH (month, day, and year) Oct 7/1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	8	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Cochrane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna F. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Joseph Hagner

(Address) 1519 N.Spring St

15 6-26-1930 192 C. HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia- Abortion (self inflicted)

(passed nozzle tip)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D. Coroner

6/25/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL June 28th 1930

20 UNDERTAKER Leo G. Cook

ADDRESS 1725 Patterson Ave

pec.—8-16-29—L. F. S.—100 Bks.

E 58297

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101 001

E 58297

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4221 Belview Ave) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edmund L. Jowers

(a) RESIDENCE NO. 4221 Belview Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6 If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Alemedia Jowers

DATE OF BIRTH (month, day, and year) Oct. 8-1863

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	8	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Custom House

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Canada

10 NAME OF FATHER Elijah Jowers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Patience Hancock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

Informant Mrs Alemedia Jowers

(Address) 4221 Belview Ave

Filed 6-1930 19 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24-30

17 I HEREBY CERTIFY, That I attended deceased from June 20 1930, to June 24, 1930, that I last saw him alive on June 24, 1930 and that death occurred, on the date stated above, at 11.40 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency Chronic (duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole, M. D.

6/26, 19 30 (Address) 770 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	June 26 1930
20 UNDERTAKER	ADDRESS
Chas. E. Franck	802 Madison Ave

ec.—1-30—M. & T.—250 Blks.

E 58298 HEALTH DEPARTMENT—CITY OF BALTIMORE É 58298

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Balto Gen Hosp ST. 11-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isadore Malinsky

(a) RESIDENCE NO. 94 Madison Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Emma Malinsky

DATE OF BIRTH (month, day, and year) April 20-1846

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84 yrs	2	5	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Malinsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Emma Malinsky

(Address) 94 Madison Ave

15 [illegible] JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25/30

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to June 25, 1930, that I last saw him alive on June 25, 1930, and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma head of pancreas

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General cachexia & Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of May 16, 1930

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) E A Kelsenger, M. D.

, 19 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew Cem

DATE OF BURIAL 6/26 1930

20 UNDERTAKER Jack Lewis 1439 E Balto St

ADDRESS

JUN 26 1930

Spec.—1-30—M. & T.—250 Blks

E 58299 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 58299

CERTIFICATE OF DEATH.

117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (Street) 12-19 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Frames

(a) RESIDENCE NO. 1913 N Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Blanche Frames

DATE OF BIRTH (month, day, and year) June 3rd 1862

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	0	21	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pharmacist

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jas T. Frames

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Sallie VanMeter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Wife. Friend.

(Address)

15 Filed ....., 19..... Registrar

HAMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-24-30

17 I HEREBY CERTIFY, That I attended deceased from 6-23, 1930, to 6-24, 1930, that I last saw him alive on 6-24, 1930, and that death occurred, on the date stated above, at 8 5 P. m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) ....yrs. ....mos 2 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical & operation

(Signed) J Leyko, M. D.

6/24, 1930 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 6/27 1930

20 UNDERTAKER Herman Cook

ADDRESS 1219 St Paul

ec.—1-30—M. & T.—250 Blks

E 58300 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58300

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 W. 33rd ST. 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert B. Beddicord

(a) RESIDENCE NO. 516 W. 33rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret A.

DATE OF BIRTH (month, day, and year) April 2, 1862

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	2	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Theodore Beddicord

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Amelia Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Margaret A. Beddicord

(Address) 516 W. 33rd St

JUN 26 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1930, to June 24, 1930, that I last saw h alive on June 24, 1930, and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) A. J. Bowers, M. D.

6-25 1930 (Address) 500 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn DATE OF BURIAL June 27 1930

20 UNDERTAKER Wm Cook ADDRESS 12 E St Paul

Spec.—1-12-23—M&T—500 Bks.

58301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

58301

REGISTERED NO. 16 82 E 58301

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) West Balto. Gen Hosp ST. Dukeland
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Klauenberg WARD
(If non-resident give city or town and State)

(a) RESIDENCE NO. (Usual place of abode) West Balto Gen Hosp ST.
How long in U. S., if of foreign birth? yrs. mos. ds.
Length of residence in city or town where death occurred yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word):
6a If married, widowed, or divorced (HUSBAND) of (or) WIFE of
7 DATE OF BIRTH (month, day, and year) 6-23-30
8 AGE: Years | Months | Days: 2 | If LESS than 1 day 36 hrs. or min.
9a OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS
10 NAME OF FATHER Theodore Klauenberg
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.
12 MAIDEN NAME OF MOTHER Mary Hoffert
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Theo Klauenberg Raydon Dukeland Co

15 Filed 6/25, 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/25/30 19

17 I HEREBY CERTIFY, That I attended deceased from 6/23/30, 19, to 6/25/30, 19, that I last saw h[illegible] alive on 6/25/30, 19, and that death occurred, on the date stated above, at 4:109 m. E.S.T

The CAUSE OF DEATH* was as follows:
Broncho pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Fracture right humerus
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical
(Signed) C. A. Alesen, M. D.
19 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem
DATE OF BURIAL: June 26 1930
UNDERTAKER: John Ulrich
ADDRESS: 2008 Eutaw

Spec.—1-10-21—M&T—1500 Blks.

William Theodore Fricke

E 58302 HEALTH DEPARTMENT—CITY OF BALTIMORE 131 E 58302

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5508 Benton Heights Ave. ST. 27-43 WARD)

2-FULL NAME William Theodore Fricke

(a) RESIDENCE NO. 5508 Benton Heights Ave. ST., 27 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 5, 1863

7 AGE — Years: 66 — Months: 7 — Days: 20 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant, retired

(b) General nature of industry, business, or establishment in which employed (or employer): General store

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Fricke

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Carrier

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant: Mrs. Catherine Fricke
(Address) 5508 Benton Heights Ave.

15 Filed ..... C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1929, to June 25, 1930.

that I last saw him alive on June 24, 1930,

and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Cystitis and Pyonephrosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic Examination

(Signed) A. L. Wilkinson, M. D.

25 30 A. L. Wilkinson
Jun., 19 (Address) 5713 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: June 21 1930

20 UNDERTAKER: John Ullrich — ADDRESS: 2005 Orleans

c.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58303

E 58303

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 2608 W. Fayette St. 20-69 WARD)

2-FULL NAME Berthe M. Gregory

(a) RESIDENCE NO. 2608 W. Fayette St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~ yrs. 1 mos. ~ ds. How long in U. S., if of foreign birth? ~ yrs. ~ mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin Gregory

DATE OF BIRTH (month, day, and year) May 6 1891

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	1	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer))

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Daniel Rebhan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk Virginia

12 MAIDEN NAME OF MOTHER Mary E. Mentzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mr. Edwin Gregory
(Address) 2608 W. Fayette St

15 Filed ..... C. HARRISON JONES, M. D. Registrar

JUN 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1929, to June 25, 1930, that I last saw h.. alive on June 24, 1930, and that death occurred, on the date stated above, at 12 pm.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wesley Sloan, M. D.

June 25, 1930 (Address) 729 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 27 1930
20 UNDERTAKER Charles L. Ewing	ADDRESS 2 Font. Ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58304 179 E 58304

CERTIFICATE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 602 Bradley St. 17-25 Ward)

2-FULL NAME Robt Grafham

(a) RESIDENCE NO. 602 Bradley St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife

6 DATE OF BIRTH (month, day and year): Sept 15 1870

7 AGE: Years 60 | Months 2 | Days 17 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Private
(c) Name of employer: Self

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER: Geo Graham

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER: Rosella Lee

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant: Mrs Graham
(Address) 602 Bradley

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) June 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) ..... M. D.

, 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: June 26 1930

20 UNDERTAKER: Joseph A Lively — ADDRESS: 4098 Mound St

FILLMORE JONES, M. D.

26 1930

cc.—1-30—M. & T.—250 Bks.

E 58305 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58305

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 15-67 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (NO.

2-FULL NAME Cody Bellison

(a) RESIDENCE NO. 3007 Westwood ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Bellison

DATE OF BIRTH (month, day, and year) Oct. 9, 1876

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	7 8	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Westminster

(State or country) Maryland

10 NAME OF FATHER Milton L. Bellison

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Clara C. Willis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 6 26 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to June 25, 1930,

that I last saw him alive on June 25, 1930,

and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hugh Arnold Jr., M. D.

6-26, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Co. Bethesda Cemetery. DATE OF BURIAL June 28 1930.

20 UNDERTAKER L. M. Nott & Sons Westfield Md. ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58306

CERTIFICATE OF DEATH

74-001

E 58306
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1705 N. Mount St. 15-21 (Ward)

2-FULL NAME Mary Catherine Pettis

(a) RESIDENCE NO. 1705 N. Mount St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Aberdeen Md.
(State or country)

PARENTS

10 NAME OF FATHER Abraham Jacobs
11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)
12 MAIDEN NAME OF MOTHER Mary Brown
13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Myrtle Pettis
(Address) 1705 N. Mount

15 Filed ..., 19.. HAMILTON JONES, M. D. Registrar
JUN 6 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) Sudden

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) H. Leech, M. D.
June 24 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Aberdeen Md

DATE OF BURIAL 6/26/30

20 UNDERTAKER Samuel A. Hensley

ADDRESS 578 N. Bradford

Cor.—10-10-29—A Co.—100 Bks.

E 58307

HEALTH DEPARTMENT—CITY OF BALTIMORE

38E 58307

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. S. 11-74 (Ward)

2-FULL NAME Ollie Colbert

(a) RESIDENCE NO. 151 Eaton Al. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Williams

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	33			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Wm. Colbert
(Address) 151 Eaton

JUN 26 1930 C. HARRISON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23rd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) ... yrs. ... mos. ...

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) ... M. D.

June 25 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 6/26 1930

UNDERTAKER Samuel T. Hemsley

ADDRESS 1711 Bolton

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58308

CERTIFICATE OF DEATH.

E 58308

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 834 Chauncey Av St. B-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Meth

(a) RESIDENCE. NO. 834 Chauncey Av ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hannah Meth

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE — Years: 72 — Months: 1858 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Herman Meth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Hannah Lindauer

13 BIRTHPLACE OR MOTHER (city or town) (State or country): Russia

14 Informant: Adolph Meth (Son)
(Address) 834 Chauncey Av

15 Filed JUN 26 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25 1930

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to June 25, 1930

that I last saw h alive on June 24, 1930,

and that death occurred, on the date stated above, at 4. A. m.

The CAUSE OF DEATH* was as follows:

Arteio - Sclerotic Hypertension

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Coronary Thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Surg

(Signed) Joseph Sindler, M. D.

19 (Address) 2348 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run

DATE OF BURIAL: June 26 1930

20 UNDERTAKER: S Lemmon Bro

ADDRESS 1272 Eutaw

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58309

CERTIFICATE OF DEATH

202 /

E 58309

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Enroute

City of Baltimore: (No. St. Joseph Hospital St. 10-14 Ward)

2-FULL NAME John. C. Weipert

(a) RESIDENCE NO. 1045 N. Central Ave. St., 10 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 09 mos. 15 ds. How long in U. S., if of foreign birth Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Cecelia. E. Weipert (Wife)

6 DATE OF BIRTH (month, day, and year)
August-9-1892

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	37	10	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plumbing bussiness
(b) General nature of industry, business, or establishment in which employed (or employer) for himself
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John. C. Weipert

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Margaret. A. Suess

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Cecelia. E. Weipert
(Address) No. 1045 N. Central Ave.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

JUN 26 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-24-1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Injuries to chest & abdomen. Brick Wall fell on him while at work at 1309 Harford Ave.

Accidental (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) , M. D.

6/25-1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Holy Redeemer Cemetery

DATE OF BURIAL 6/27/30 19

20 UNDERTAKER Henry Hoeck Sons, Inc.

ADDRESS 1301 Eager St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58310

E 58310

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 916 S Potomac St. 1-1 Ward)

2-FULL NAME Alice Hutson

(a) RESIDENCE NO. 916 S Potomac St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm. H. Hutson

6 DATE OF BIRTH (month, day, and year) March 16 1892.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	38	3	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General naturo of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Adolph Faber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Mooney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Sharpstown, Md.

14 Informant Wm. H. Hutson
(Address) 916 S. Potomac St.

15 Filed ....., 19.... C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Broken Compensation (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) C. C. Stadt, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Mt. Carmel Cemetery

DATE OF BURIAL
June 28 1930

20 UNDERTAKER
George W. Zirkler

ADDRESS
1737 E. Eager st

JUL 3 1930

Cor.—10-10-29—A Co.—100 Bks.

Boleslaw Pakula

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58311

CERTIFICATE OF DEATH

E 58311

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St. 2-4 Ward)

2-FULL NAME Boleslaw Pakula

(a) RESIDENCE NO. 1818 Aliceanna St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of Catherine Pakula
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May-15-1900

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	30	1	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Yard House Labor
(b) General nature of industry, business, or establishment in which employed (or employer) American Smelting & Refining Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER Vincent Pakula
11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Catherine Pakula
(Address) 1818 Aliceanna Street

15 Filed ..... 19.. Registrar C. HARRISON JONES, M. D.

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24- 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis
Ten hours.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? American Smelting & Refining Co.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. T. Reese, M. D.

June 26, 1930 (Address) 1659 Bonner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery

DATE OF BURIAL June 28- 1930

20 UNDERTAKER George A. Weber

ADDRESS 705 S. Amity St.

Sedgwick

...ec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58312 — 129 — E 58312

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (a) 5330 Lafayette Ave (No.) (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sadie Hedgwick

(a) RESIDENCE NO. 5330 Lafayette Ave ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	widow

6 If married, widowed, or divorced, HUSBAND of (or) WIFE of David Hedgwick

DATE OF BIRTH (month, day, and year) Mar 858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	72	3		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) New Jersey

10 NAME OF FATHER John Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant Sarah E. Mowbray

(Address) 5330 Lafayette Ave

15 6-26 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25-1930

17 I HEREBY CERTIFY, That I attended deceased from 6-2- 1930, to 6-24 1930

that I last saw her alive on 6-24 1930

and that death occurred, on the date stated above, at 5:25 a. m.

The CAUSE OF DEATH* was as follows: Cerebral apoplexy

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Hyp. H. Prostration & Nephritis

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. H. Brown, M. D.

6-25 1930 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL June 27 1930

20 UNDERTAKER Thomas E. Wheeler — ADDRESS 200 Mt. Lexington

pec.—2-29-28—L. F. S.—500 Bks.

58313

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓

E 58313

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S. Ann ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. McClain

(a) RESIDENCE NO. 319 S. Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

If married, widowed, or divorced (or) WIFE of Thos. J. McClain

DATE OF BIRTH (month, day, and year) May 16-1878

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	1	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER Patrick Corcoran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Feeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Thos. J. McClain

(Address) 319 S. Ann St.

Filed ... 19 ... Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25-30

17 I HEREBY CERTIFY, That I attended deceased from June 20th 1930 to June 25th 1930

that I last saw her alive on June 24th 1930

and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms.

(Signed) Amelia E. Link M. D.

6/26th 1930 (Address) 1717 N Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	June 28 30
20 UNDERTAKER J. G. Moran	ADDRESS 3000 E. Balto.

6 25 1930

spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58314

CERTIFICATE OF DEATH.

161-001 E 58314

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 11-24 WARD)

2-FULL NAME Baby girl Mottley.

(a) RESIDENCE NO. 433 Mason ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single.

6a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 16-1930

7 AGE — Years: — Months: — Days: 1 — If LESS than 1 day, hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER George Mottley

11 BIRTHPLACE OF FATHER (city or town) Gettysville (State or country) Va.

12 MAIDEN NAME OF MOTHER Viola Speight

13 BIRTHPLACE OF MOTHER (city or town) Whiteoak (State or country) N.C.

14 Informant Mother.
(Address) —

15 [illegible] C. HAMPSON JONES, M. D. Registrar

JUN 25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1930

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to June 17, 1930, that I last saw her alive on June 17, 1930, and that death occurred, on the date stated above, at 12:30 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia.
Premature (37 wks)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Daniel A. Dashiell M. D.

6/20 1930 (Address) Emmitsburg Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: JUN 26 1930

20 UNDERTAKER: Commissioner Health

ADDRESS

Dr. Wm. S. WOODALL

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58315 E 58315

CERTIFICATE OF DEATH

47

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 Cathedral ST. 11th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Georgie Graham Bright

(a) RESIDENCE NO. 814 Cathedral ST., 11 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Jan 14th 1852

AGE: Years 77 Months 5 Days 10 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Madison, Indiana

10 NAME OF FATHER Jesse D. Bright

11 BIRTHPLACE OF FATHER (city or town) Norwich (State or country) New York

12 MAIDEN NAME OF MOTHER Mary E. J. Turpin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Powhatan County Va

14 Informant Francis E. Bright Jr

(Address) 814 Cathedral St

15 Filed 6-30-30 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to June 24, 1930, that I last saw her alive on June 24, 1930, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast (duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Metastasis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) H Warren Buckler, M. D.

June 30 1930 (Address) 806 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL June 27 1930

20 UNDERTAKER Henry Herbert Sons

ADDRESS Cathedral

Spec.—1-10-21—M&T—1500 Blks.

E 58316

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58316

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 Perkins St ST. 21-29 (WARD)

2-FULL NAME Martin Healy,

(a) RESIDENCE NO. 116 Perkins St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Mary Sweeney, 1572

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer, 034

(b) General nature of Industry, business, or establishment in which employed (or employer) Grocery Store.

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) County Mayo. Ireland.

PARENTS

10 NAME OF FATHER Thomas Healy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Sarah Burke,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mary Healy (Wife)

(Address) 116 Perkins St.

15 6 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24. 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 1. 1930. to June 24. 1930.

that I last saw him alive on June 24. 1930.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Epilepsy.

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of —

Was there an autopsy? no. —

What test confirmed diagnosis? Physical Examination.

(Signed) Johnston Jones, M. D.

6/26/ 1930 (Address) 888 Mt Lemmond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 6/27/30

20 UNDERTAKER H. C. Hammond Son Co.

ADDRESS 113 E Lexington St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58317

E 58317

CERTIFICATE OF DEATH

118-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital (Ward) 4-30

2-FULL NAME Herbert Carey (Jr)

(a) RESIDENCE NO. Patapsco Park, Brooklyn, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	0	11	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Herbert Carey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Edna Green

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Edna Carey
(Address) Patapsco Park Md.

Filed JUN 26 1930 C. HAMPSON JONES M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Intussusception

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

6/25 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mark Cemetery Harmans Md

DATE OF BURIAL June 26, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St

...ec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58318 E 58318

CERTIFICATE OF DEATH

1—PLACE OF DEATH Hospital of St. Vincent of Maryland REGISTERED NO. 76-71 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lafayette and John ST., WARD)

2—FULL NAME Mary Eva Maguire

(a) RESIDENCE NO. 60 E Eutaw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 9 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced RUSBAND of (or) WIFE of Matthew Maguire

DATE OF BIRTH (month, day, and year) October 23, 1888

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
41	42	9	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, Maryland (State or country)

10 NAME OF FATHER John Boyd Keller

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country) D.C.

12 MAIDEN NAME OF MOTHER Elizabeth Lenhart

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

Informant John Boyd Keller (Father)

(Address) 501 Washington Avenue

Filed ..., 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 '30

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1930, to June 26, 1930, that I last saw h.r alive on June 26, 1930 and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs

(Signed) Edw. Y. Kirkpatrick, M. D.

, 19 (Address) Union Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL June 30 1930

20 UNDERTAKER E. H. Conklin ADDRESS 924 Eutaw

Spec. - 1-10-21 - M&T - 1500 Blks.

E 58319

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 58319

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4022 Bonner Rd ST. 15-65 WARD

2-FULL NAME John Kelly.

(a) RESIDENCE NO. 4022 Bonner Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~ or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist 67½

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Del.
(State or country)

PARENTS

10 NAME OF FATHER John Kelley

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs. J. Kelley
(Address) 4022 Bonner Rd.

15 6/25/30 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25-1930

17 I HEREBY CERTIFY, That I attended deceased from May 15th, 1930, to June 25, 1930

that I last saw h[illegible] alive on June 25, 1930

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

a Myocarditis.
b Endocarditis.
c
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Allerick Lozelle M. D.

19 (Address) 3705 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	June 27, 30
20 UNDERTAKER	ADDRESS
Martin Haley & Sons	1027 W. North Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58320

CERTIFICATE OF DEATH

167-E 001 58320

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1909 Mc Keon Ave Ward) 15-71

2-FULL NAME Henry H Horstman

(a) RESIDENCE NO. 1909 Mc Keon St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M.	W.	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Genevieve Horstman

6 DATE OF BIRTH (month, day, and year) March 13, 1856

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
74	3	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Police
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Horstman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs C. Horst
(Address) 1909 Mc Keon Ave

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar
6 1930 by ... clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows:
Suicide
Ill. Gas Poisoning
(duration) ... yrs. ... mos. — ds.

CONTRIBUTORY (Secondary) Asthma
(duration) ... yrs. ... mos. — ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? No
What test confirmed diagnosis? Phy History
(Signed) G. L. Blades, M. D.
, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 28 1930.
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 W North

pec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58321

CERTIFICATE OF DEATH

129 E 58321

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6312 Marietta Ave WARD 47-43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine M. Sader

(a) RESIDENCE NO. 6312 Marietta Ave WARD 47

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 3 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Sader

DATE OF BIRTH (month, day, and year) March 15, 1854

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	3	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER Ignatius Zinkand

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs Catherine Canard

(Address) 6312 Marietta Ave

15 Filed JUN 26 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1930

17 I HEREBY CERTIFY, That I attended deceased from June 15 1930 to June 26 1930

that I last saw h alive on June 26 1930

and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Hypertension Arteriosclerosis

Pneumonia (2 days)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? Symptoms

(Signed) Thos. F. Sterne M. D.

6/26/30 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL June 30 1930

20 UNDERTAKER Henry Hoeck Sons Inc.

ADDRESS 301 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58322

CERTIFICATE OF DEATH.

E 58322

REGISTERED NO. 91

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 Preston St. WARD)

2-FULL NAME Jefferson Arnett

(a) RESIDENCE NO. 223 Preston St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE Years 80 Months Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Md. "

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Gordon (Address) 223 Preston St.

15 Filed 6 26 1930 C. HAMPSON JONES, M. D. Registrar per Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1930 to June 27 1930

that I last saw h[illegible] alive on June 27 1930

and that death occurred, on the date stated above, at 7 H. m.

The CAUSE OF DEATH* was as follows:

30 Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Thomas, M. D.

19 (Address) 974 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem. | DATE OF BURIAL 6-26 1930

20 UNDERTAKER Samuel Carson | ADDRESS 916 Park Ave

Spec.—1-12-23—M&T—500 Bks.

E 58323

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 E 58323

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 508 St Mary ST. (WARD) 17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Hungerford

(a) RESIDENCE NO. 508 St Mary ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced (HUSBAND of or) WIFE of: Clara Hungerford

6 DATE OF BIRTH (month, day, and year): - - 1865

7 AGE: Years 65 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Charles Co Md

PARENTS

10 NAME OF FATHER: Joshua Hungerford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Chas Co Md

12 MAIDEN NAME OF MOTHER: Mc Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Chas Co Md

14 Informant: Lettie Smyth

(Address) 508 St Mary

15 Filed 6 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1930

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1930, to June 24, 1930,

that I last saw h— alive on June 24, 1930,

and that death occurred, on the date stated above, at 9.8 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Primary

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. S. Howell M. D.

(Address) 201 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 6-26 1930

20 UNDERTAKER: Dawson Eaton

ADDRESS: 716 Pa Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58324 E 58324

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen Hosp ST. 13-52 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David B. Reckord

(a) RESIDENCE NO. 4105 Roland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna B. Reckord

6 DATE OF BIRTH (month, day, and year) 11/11/1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturers Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Reckord

11 BIRTHPLACE OF FATHER (city or town) (State or country) New England State

12 MAIDEN NAME OF MOTHER Tabitha Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Anna B. Reckord

(Address) 4105 Roland Ave

15 Filed 6 26 1930, 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to June 26, 1930,

that I last saw him alive on June 26, 1930,

and that death occurred, on the date stated above, at 3:25 P.M.

The CAUSE OF DEATH* was as follows:

Hypertension cardio-vascular disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 15 days

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & laboratory

(Signed) S. A. Aleen, M. D.

, 19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mountain Cemetery

DATE OF BURIAL 6/28/1930

20 UNDERTAKER Wm Cook 1217 St Paul St

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58325

CERTIFICATE OF DEATH.

E 58325

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4352 E. 20th St. (Ward) 12-50

2-FULL NAME Isaac Sterner

(a) RESIDENCE NO. 4352 E. 20th St., WARD ..... (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Last) Sophronia Jane Sterner

6 DATE OF BIRTH (month, day, and year) June 15th 1852

7 AGE: Years 78 Months ..... Days 11 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 03

(b) General nature of industry, business, or establishment in which employed (or employer): Locomotive Engineer

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Hereford Md.

PARENTS

10 NAME OF FATHER David Sterner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Hirshman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Jere H. Sterner 420 Normandy Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

By .....

6 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1930

17 I HEREBY CERTIFY, That I attended deceased from October 30, 1929, to June 26, 1930.

that I last saw him alive on June 26, 1930.

and that death occurred, on the date stated above, at 8:25 A m. C.S.T.

The CAUSE OF DEATH* was as follows:

Apoplexy

Hemiplegia of left side (duration) ..... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Heart failure (duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Reginald J. Tonry, M. D.

6-24 1930 (Address) 4114 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 6/28/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Blks.

Dr Phil J. Kinzey
2700 Hartford Ave

E 58326 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58326

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 5925 Belona Ave WARD 47-48

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert W. Harrison

(a) RESIDENCE NO. 5925 Belona Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Mary Elizabeth

DATE OF BIRTH (month, day, and year) 3/28/1854

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	2	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electro Typer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) Balto (State or country) Md

10 NAME OF FATHER James Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amanda Metcalf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

PARENTS

14 Informant Chas E. Harrison

(Address) 503 Crowson Ave

15 6 26 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/25/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1929, to June 25, 1930, that I last saw him alive on June 23, 1930, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Chr. nephritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Phil J. Kinzey, M. D.

6/26, 1930 (Address) 2700 Hartford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 6/25/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

Rec.—1-30—M. & T.—250 Blks

58327

E 58327

HEALTH DEPARTMENT—CITY OF BALTIMORE

131

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. 7-53 WARD)

2-FULL NAME Jas Harter B. Hull

(a) RESIDENCE NO. 300 Edgevale Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Hilda Porter Hull

DATE OF BIRTH (month, day, and year) July-6-1892

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	11	20	19

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Automobile dealer 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Iowa (State or country)

PARENTS

10 NAME OF FATHER J. H. Hull

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)

12 MAIDEN NAME OF MOTHER Frances Barnes

13 BIRTHPLACE OF MOTHER (city or town) Iowa (State or country)

14 Informant Hosp Records (Address)

Filed 2-7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1930, to June 25, 1930, that I last saw him alive on June 25, 1930, and that death occurred, on the date stated above, at 10:30 A.M. (Forty Standard Time)

The CAUSE OF DEATH* was as follows:

Staphylococcus Pyaletis

(duration) yrs. 4 mos da.

CONTRIBUTORY (Secondary) abscessed Hip

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? 3/22/30

Did an operation precede death? yes Date of 3/31/30 drainage 4/6/30 7/10/30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edwin B Jones M. D.

19 (Address) 1119 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oskaloosa, Iowa

DATE OF BURIAL June 28 1930

UNDERTAKER Stewart & Mowers Company

ADDRESS 108 W. North Ave.

ec.—2-29-28—L. F. S.—500 Pks.

E 58328

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 E 58328

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Franklin Sq Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. ST. 16-27 WARD)

2—FULL NAME Mrs Dora Cocnavitch

(a) RESIDENCE NO. 621 N Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Cocnavitch

DATE OF BIRTH (month, day, and year) June 1st 1881

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	49	0	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 039

(r) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Louis F. Barthe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Mary C. Dettmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Edward Cocnavitch

(Address) 621 N. Payson st

15 [illegible] C. HAMPSON JONES, M. D. Registrar

27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1930, to June 24, 1930, that I last saw h Cr alive on June 24, 1930 and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Auricular fibrillation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms.

(Signed) Arthur Matteson, M. D.

6/24 1930 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	June 27 1930
20 UNDERTAKER E. Schleman & Son	ADDRESS 1039 Hanover

Cor.—10-10-29—A Co.—100 Bks.

58329

HEALTH DEPARTMENT—CITY OF BALTIMORE

58329

31

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Jacob City Hospital St. 6-9 Ward)

2-FULL NAME Jacob Greenstein

(a) RESIDENCE NO. 1600 E Balto. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pearl Greenstein

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Journeyman
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER unknown Greenstein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Pearl Greenstein
(Address) 1500 E Balto md.

15 Filed JUN 27 1930 C. HAMPSON JONES, M. D. Registrar

For

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

June 27 1930 (Address) 7002 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Circle — DATE OF BURIAL 6/27 1930

20 UNDERTAKER Jack Lewis 1439 E Balto St — ADDRESS

spec.—1-30—M. & T.—250 Blks.

E 58330 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 58330

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2224 E. Lombard ST. 1-3 WARD)

2-FULL NAME Mr Joseph Goldstein

(a) RESIDENCE NO. 2224 Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	white	Husband

6 If married, widowed, or divorced HUSBAND of or) WIFE of Lena Goldstein

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isidore Goldstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lena Goldstein (Address) 2224 E Lombard St

15 Filed JUN 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-26-30

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1930, to June 26 1930, that I last saw him alive on June 26, 1930, and that death occurred, on the date stated above, at 12.48 P. m.

The CAUSE OF DEATH* was as follows:

(Malignancy) Lymphosarcoma of mediastinum

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis Faine, M. D.

6/26 1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rumm

DATE OF BURIAL 6/27 1930

UNDERTAKER Jacob Levin ADDRESS 1434 Eastern Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58331

58331

CERTIFICATE OF DEATH.

90

12-50

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Homewood Apts. (ST.) (WARD)

2-FULL NAME Barbara Strobel Winks

(a) RESIDENCE NO. Homewood Apts., Charles & 31st Sts. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William M. Winks

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	7	27 28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Strobel

11 BIRTHPLACE OF FATHER (city or town) Balto., (State or country) Md.

12 MAIDEN NAME OF MOTHER Eleanora Jenkins

13 BIRTHPLACE OF MOTHER (city or town) Balto., (State or country) Md.

14 Informant William M. Winks (Address) Homewood Apts., Chas. & 31st

15 Filed JUN 27 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1930

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1930, to June 26, 1930, that I last saw h alive on June 26, 1930, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia & coma due to Cerebral Hemorrhage

(duration) — yrs. — mos 12 ds.

CONTRIBUTORY (Secondary) Ch. Valv. Endocarditis

(duration) [illegible]

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? C

(Signed) Jefferis Busk M. D.

6/27 1930 (Address) 5. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL June 30 1930

UNDERTAKER John O. Mitchell & Sons, Mahlon B. Mitchell

ADDRESS 1900 Eutaw Pl

DEC.—1-30—M. & T.—250 Blks.

E 58332 HEALTH DEPARTMENT—CITY OF BALTIMORE 194 E 58332

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Bolton ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ann Martien

(a) RESIDENCE No. 1609 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto.
(State or country) Md.

10 NAME OF FATHER Wm. Martien

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER ---

13 BIRTHPLACE OF MOTHER (city or town) ---
(State or country) ---

Informant Carey Martien
(Address) 1813 Thornbury Road

Filed JUN 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26-30.

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1930, to June 26, 1930.

that I last saw her alive on June 26, 1930,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Ideat Prostration —

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) Many yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None —

(Signed) Chas W. Lumsden M. D.

June 27 1930 (Address) 1327 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL June 28 1930

20 UNDERTAKER John O. Mitchell & Sons

ADDRESS 1900 Eutaw Pl.

Malcolm B. Mitchell

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58333

58333

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Port. (St.) Guil[illegible] (Ward)

2-FULL NAME Mr. Randolph Matthews

(a) RESIDENCE NO. 3009 (St.) Ferndale Ave. (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Imogen Rothel Matthews

6 DATE OF BIRTH (month, day, and year) Sept 6 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Eli Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Mary Orrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Information Given by Mrs Randolph Matthews (Address) 3009 Ferndale Road

15 Filed JUN 27 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1930

I HEREBY CERTIFY, That I attended deceased from June 24, 1930, to June 25, 1930, that I last saw h[illegible] alive on June 25, 1930, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Cardio renal Failure

Pulmonary Edema

4 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Second + Third degree Burns (duration) yrs. mos. Over

Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) W. Balto Ave. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL June 27 1930

17 UNDERTAKER John O. Mitchell & Sons ADDRESS 19-25 Eutaw Pl

Marlon E. Mitchell

Dr. Hampson Jones Coroner

ec.—1-30—M. & T.—250 Bks

E 58334 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58334

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) 23-31 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ledley

(a) RESIDENCE NO. 1102 Leadenhall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 2-16-69

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	4	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice house

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Wm. Ledley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia Porper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed JUN 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-26-30

17 I HEREBY CERTIFY, That I attended deceased from 1-22-29, 19..., to 6-26-30, 19...,

that I last saw him alive on 6-26-30, 19...,

and that death occurred, on the date stated above, at 10:00 A.M.

The CAUSE OF DEATH* was as follows:

Asthma

Morethon (duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic & acute (duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture.

(Signed) Paul Podgt., M. D.

6-26 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

DATE OF BURIAL June 28, 1930

UNDERTAKER D. Thurnwald Son

ADDRESS 3615 Bluefield Ave

ec.—2-29-28—L. F. S.—500 Bks.

E 58335

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58335

CERTIFICATE OF DEATH

REGISTERED NO. 51

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1938 Chesapeake Ave. Hanfield WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Chase Hayes Barton

(a) RESIDENCE NO. 1938 Chesapeake Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Joe Hayes

DATE OF BIRTH (month, day, and year): Oct 27 1908

AGE: Years 21 | Months 7 | Days 27 | If LESS than 1 day.....hrs. or.....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Hanfield Md.

10 NAME OF FATHER: John Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country): Charles County Md.

12 MAIDEN NAME OF MOTHER: Lillie Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Charles Co Md.

14 Informant: John Chase Jr (Brother)

(Address): 3326 Tivoli

15 FILED JUN 27 1930

C. HAMPSON JONES, M.D. (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1930 to June 24, 1930

That I last saw her alive on June 24, 1930

and that death occurred, on the date stated above, at 6 15 P m. ST.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(Rheumatic Cardio-Vascular).

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Acute Rheumatic Fever

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? History & Physical

(Signed) George McDonald, M. D.

19 (Address) 906 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery

DATE OF BURIAL: June 28, 1930

20 UNDERTAKER: Mrs. Katie R Williams

ADDRESS 322 Schroeder St

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58336 | 188-103 | E 58336

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hos ST., 20-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas How'd Greenwalt

(a) RESIDENCE NO 2110 Penrose Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 1860 (age)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	11	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Sam'l Greenwalt

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs. Mary E. Smith

(Address) 2110 Penrose Ave.

15 Filed 1-27 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Walked into side of moving auto truck

(duration) yrs. mon ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fletcher Bates

Did an operation precede death? no Date of Decomposition

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Frank Coroner, M. D.

6/27, 1930 (Address) 2930 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery DATE OF BURIAL June 27 1930

20 UNDERTAKER George E. Johnson & Son ADDRESS 1101 Eutaw Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58337

CERTIFICATE OF DEATH

129 E 58337

REGISTERED NO. 2434

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Covington St. ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Loretta M. Smith

(a) RESIDENCE NO. 1407 Covington St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 4 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Howard E. Smith

DATE OF BIRTH (month, day, and year) Feb. 22 1893

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	4	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER John Keys

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Marion E. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs. Smith

(Address) 1407 Covington St

Filed N 27 1930 HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) K June 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1930, to June 25, 1930,

that I last saw h er alive on June 24, 1930

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

and mitral regurgitation of heart

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? - - - -

Did an operation precede death? no Date of - - -

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) Thos Keibel M. D.

6/27 1930 (Address) 1224-1226 Hanover Street, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 6/28 1930

20 UNDERTAKER J. Frew McCully

ADDRESS 130 E Fort

Rec.—1-30—M. & T.—250 Blks.

R 38189 Red E 58338

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 58338

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 24-24 (WARD)

CITY OF BALTIMORE: (NO.)

2-FULL NAME Oscar Rogers

(a) RESIDENCE NO. 1613 Lawrence ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or ~~Divorced~~, (write the word)
Male	Black	Child

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Mar. 3, 1928

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	2	3	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Frances Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 27 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24-1930

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to June 24, 1930, that I last saw him alive on June 24, 1930, and that death occurred, on the date stated above, at 10 10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 13 ds. (?)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? not Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. M. Buckland, M. D.

6/25/30 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 6/27, 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Presstman St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58339

CERTIFICATE OF DEATH.

74-001

74 E 58339

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2208 Division St., 14-59 WARD)

2-FULL NAME Isaac Comegys

(a) RESIDENCE NO. 2208 Division St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elizabeth Comegys

6 DATE OF BIRTH (month, day, and year) — — 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): 970

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Centreville Md

PARENTS

10 NAME OF FATHER Samuel Comegys

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Minnie Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Elizabeth Comegys

(Address) 2208 Division St

Filed JUN 27 1930 H. C. HAMILTON JONES, M. D. Registrar

per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1930 to June 23, 1930, that I last saw him alive on June 23, 1930, and that death occurred, on the date stated above, at 5:50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arteriosclerosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Hy Was Bronchitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. L. Elder, M. D.

6/24, 1930 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery — DATE OF BURIAL: 6/27 1930

UNDERTAKER: Thomas E. Kelson — ADDRESS: 1302 Preston St

pec.—1-30—M. & T.—250 Blks.

58340

HEALTH DEPARTMENT—CITY OF BALTIMORE VE 58340

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 6204 Baltimore ST. 7-1-55 WARD)

2-FULL NAME Lucinda R Yingling

(a) RESIDENCE No. 6204 Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Ephraim Yingling

DATE OF BIRTH (month, day, and year) April 11 35

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	94	2	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER John C Hornberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Menges

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Charles Erving

(Address) 6204 Baltimore St

15 Filed 6-27-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25-1930

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 12, to June 25, 1930,

that I last saw h/W alive on June 25, 1930,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest L Kahn, M. D.

6/26 1930 (Address) 3033 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL June 27 1930

20 UNDERTAKER W M Routzens

ADDRESS 223 W North

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58341 — CERTIFICATE OF DEATH. — 129 E 58341

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 657 W Franklin ST. 17-25 WARD)

2-FULL NAME George Proctus Hilton

(a) RESIDENCE NO. 657 W Franklin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) 12/14/1861

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	6	12	

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work R. R. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Secretarial
(c) Name of employer B & O. RR

10 BIRTHPLACE (city or town) (State or country) Montgomery Co Md

PARENTS

11 NAME OF FATHER Geo W. Hilton

12 BIRTHPLACE OF FATHER (city or town) (State or country) Mont Co Md

13 MAIDEN NAME OF MOTHER Francis Scott

14 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant Chas Scott Hilton
(Address) Howard Co and Franklin

Filed JUN 27 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26 1930

17 I HEREBY CERTIFY, That I attended deceased from January 8th, 1927, to June 26th 1930, that I last saw h[illegible] alive on 6/26, 1930, and that death occurred, on the date stated above, at 12 — m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis
(duration) 3 yrs. 6 mos 18 ds.

CONTRIBUTORY (Secondary) Coma
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? Laboratory Clinical

(Signed) Gustav W Adelman, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkesburg Md.

UNDERTAKER W M Knudson

DATE OF BURIAL June 29 1930

ADDRESS 2430 W Balto

ec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58342

E 58342

CERTIFICATE OF DEATH.

REGISTERED NO. 17 E 58342

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. University Hospital WARD) 13-54

2-FULL NAME Helena Hoffman

(a) RESIDENCE NO. 2400 E. Madison St ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND) of or) WIFE of Valentine Hoffman

DATE OF BIRTH (month, day, and year) Oct. 15, 1890

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	8 9	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 37

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

BIRTHPLACE (city or town) Balto. Md.
(State or country)

10 NAME OF FATHER Adolf Auslauf

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Senior

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Valentine Hoffman
(Address) 2400 E. Hoffmann

15 Filed 19 H. JAMES JONES, M. D. Registrar

27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25-30

17 I HEREBY CERTIFY, That I attended deceased from 6-19, 1930, to 6-25, 1930, that I last saw h.. alive on 6-25, 1930, and that death occurred, on the date stated above, at 5.20 a.m.

The CAUSE OF DEATH* was as follows:

Appendicreal Abscess

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Pneumonia Bilateral (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6-20-30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M.C. Partridge, M. D.

6-25, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem.

DATE OF BURIAL June 28, 1930.

20 UNDERTAKER Wm. C. Miller & Son

ADDRESS 2334 Jefferson St.

sec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58343

CERTIFICATE OF DEATH.

129 E 58343

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5511 Gwynn Oak Ave. 28-64 WARD)

2-FULL NAME Annie Mary Emrich

(a) RESIDENCE NO. 5511 Gwynn Oak Ave. St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced (or) WIFE of Charles N. Emrich

DATE OF BIRTH (month, day, and year) May 25 1847

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83.	1	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Penna.

10 NAME OF FATHER James Fulton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Sarah A. Fulton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant John C. Emrich

(Address) 5511 Gwynn Oak Ave

15 Filed 2-7 1930 HAMP[illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1930

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1930, to June 25, 1930, that I last saw her alive on June 25, 1930, and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Senility

Arteriosclerosis

Chronic mixed nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Starvation intoxication

(duration) — yrs. — mos. 19 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical findings

(Signed) Maurice E. Shamoon M. D.

6/26, 1930 (Address) 3300 W. Dark[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL June 28 1930

20 UNDERTAKER Josiah Ryder

ADDRESS 1600 Harlem Ave

ec.—1-30—M. & T.—250 Blks.

37419
Neuro Surg.

E 58344

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58344

CERTIFICATE OF DEATH.

REGISTERED NO. 34

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST 15-64 WARD)

2-FULL NAME Maggie Heird

(a) RESIDENCE NO. 1640 Thomas Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
Female	White	Married

6 If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wilbur J. Heird

DATE OF BIRTH (month, day, and year) Mar. 3 1852.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	3	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Cornelius Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Virginia Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed ... 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25-1930

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1930, to June 25, 1930, that I last saw h[illegible] alive on June 25, 1930, and that death occurred, on the date stated above, at 3.05 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis - Pulmonary Pleural effusion terminal symptoms of cerebral complication

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cystitis (duration) yrs. mos. Nt ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-9-30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) H. Brown, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem. Co.	June 28 1930
20 UNDERTAKER Josiah Eyler	ADDRESS 1600 W North Ave

ec.—1-30—M. & T.—250 Bks.

58345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 58345

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 4200 Ashland Ave St. 16-39 WARD)

2-FULL NAME Howard R. Wright

(a) RESIDENCE NO. 4200 Ashland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Laura V. Wright

DATE OF BIRTH (month, day, and year) May 21-1856

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	1	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Franklin Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hannah Wiley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mrs Laura V. Wright

(Address) 4200 Ashland Ave

Filed JUN 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1930

17 I HEREBY CERTIFY, That I attended deceased from June 20 1930, to June 26 1930, that I last saw h— alive on June 26 1930, and that death occurred, on the date stated above, at 10:50 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Stenosis

(duration) 10 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Heart

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Geo. H. Young, M. D.

(Address) 1834 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Freedom Cem

DATE OF BURIAL July 1 1930

20 UNDERTAKER John Merrick

ADDRESS 2006 Eutaw

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58346

CERTIFICATE OF DEATH

1/2 E 58346

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2626 Harlem (St.) 16th (Ward)

2-FULL NAME Edward Marsh

(a) RESIDENCE NO. 2626 Harlem Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: Stella

6 DATE OF BIRTH (month, day, and year): Feb 1-1880

7 AGE: Years 50 | Months 4 | Days 4 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Iron worker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md.

PARENTS

10 NAME OF FATHER: Edward Marsh

11 BIRTHPLACE OF FATHER (city or town): Baltimore
(State or country): Md.

12 MAIDEN NAME OF MOTHER: Barbara Helbig

13 BIRTHPLACE OF MOTHER (city or town): Baltimore
(State or country): Md.

14 Informant: Stella Marsh
(Address): 2626 Harlem

15 Filed JUN 27 1930 H. M. JONES, M. D. Registrar

Rec'd

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Error of diet

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) ..... M. D.

June 26 1930 (Address) Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem

DATE OF BURIAL: June 28 1930

UNDERTAKER: Mr & Mrs. John W. Teufel & Son

ADDRESS: 801 W. Fayette

Rec'd

Pat

ec.—1-30—M. & T.—250 Blks.

WYBLE

E 58347 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58347

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hosp 9-17 129

CITY OF BALTIMORE: (No. Caroline & Oliver Sts. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Wyble -

(a) RESIDENCE NO. Loop a Road - Catonsville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed or divorced HUSBAND of or) WIFE of John T. Wyble

DATE OF BIRTH (month, day, and year) Oct 14th 1847

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	8	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto Co. (State or country) Md.

10 NAME OF FATHER Lloyd Mitchell

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Parlett

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs Zander (Address) Fullerton Md.

15 Filed 6-27 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25-30

17 I HEREBY CERTIFY, That I attended deceased from 6-17, 1930 to 6-25, 1930 that I last saw her alive on 6-24, 1930 and that death occurred, on the date stated above, at 5 55 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.
Chronic Bronchitis
(duration ? yrs. ? mos ds.)

CONTRIBUTORY (Secondary) Anaemia (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) M. Henderson M. D.

, 19 (Address) Dr Joseph Wyble

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	June 28 1930
20 UNDERTAKER	ADDRESS
Pratt Leadenhall	Fullerton

ec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58348 ✓ 31 E 58348

E 58348 Filed

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2668 Wilkens Ave (ST.) 20-69 (WARD)

2-FULL NAME William H. Shepherd Sr

(a) RESIDENCE NO. 2668 Wilkens ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced
HUSBAND of
or) WIFE of Louise P. Shepherd

DATE OF BIRTH (month, day, and year) June 27th 1895

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	11	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) = 09

(c) Name of employer

BIRTHPLACE (City or town) Balto.
(State or country) Md

10 NAME OF FATHER Wm. J. Shepherd

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Neild

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Louise P. Shepherd
(Address) 2668 Wilkens Ave

15 Filed 2-7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25th 30.

17 I HEREBY CERTIFY, That I attended deceased from Nov 1- 1928, to June 25 1930.

that I last saw him alive on June 25- 1930.

and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Mycobacteria.

(duration) Unknown yrs.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Norval C Nash, M. D.

June 29 30 (Address) 257 Wilkens ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Cemetery — DATE OF BURIAL 6/27/1930

UNDERTAKER J. B. Nugent — ADDRESS 185 N. Bond St

Cor.—10-10-29—A Co.—100 Bks.

John S. Kijowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58349

CERTIFICATE OF DEATH

194 E 58349

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2532 Fleet Street St., 1-2 Ward)

2-FULL NAME John S. Kijowski

(a) RESIDENCE NO. 2532 Fleet Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Kijowski

6 DATE OF BIRTH (month, day, and year) May 22, 1888

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	42	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Photographer
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Helen Kijowski
(Address) 2532 Fleet Street

15 FILED JUN 27 1930 T. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Heat Prostration

(duration) ..... yrs. ..... mos. 1/4 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 1706 Eastern Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M. Fenton, M. D.

6 26 1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery

DATE OF BURIAL June 30 1930

20 UNDERTAKER George A. Weber 705 E Lanvale St

ADDRESS

Dec.—1-30—M. & T.—250 Blks. Elizabeth Holland ✓

38242
E 58350

HEALTH DEPARTMENT—CITY OF BALTIMORE E 58350

CERTIFICATE OF DEATH.

146

REGISTERED NO. 13-54

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD) Eliz Holland

2-FULL NAME ~~Betty James~~ Elizabeth Holland

(a) RESIDENCE NO. 2323 Eutaw ST., Rd WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced (or) WIFE of John Holland

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md -

10 NAME OF FATHER Adam Benner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Claudia Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Records -
(Address) JOHNS HOPKINS HOSPITAL

Filed JUN 27 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25-30

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to June 25-, 1930, that I last saw her alive on June 25-, 1930, and that death occurred, on the date stated above, at 5.10 p. m.

The CAUSE OF DEATH* was as follows:

Staphylococcus (aureus) septicemia

(duration) ..... yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Puerperal Infection

(duration) ..... yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6-21-30

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Charles H Peckham, M. D.

6-26-19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL 6/28 1930

20 UNDERTAKER C. Vernon Lemmon

ADDRESS 4611 Ph. Hgts Rd.

Dec.—1-30—M. & T.—250 Bks.

E 58351 E 58351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3409 Foster Ave ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Nuedling

(a) RESIDENCE NO. 3409 Foster ave ST., 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Elizabeth Nuedling

DATE OF BIRTH (month, day, and year) Jan. 20th 1884

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	5	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman of Packing

(b) General nature of industry, business, or establishment in which employed (or employer) Plant

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Innocence Nuedling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Hopp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Nuedling

(Address) 3409 Foster Ave

Filed 6-27-1930, 19 C. TRAWICK JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24th/30

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1929, to June 24, 1930

that I last saw h alive on June 24, 1930

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

Laryngeal Tuberculosis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Heart Pertubation

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Roentgen Diagnosis

(Signed) H. H. Hamilton M. D.

6/25, 1930 (Address) 3508 Bank St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL June 27th 1930

UNDERTAKER Lilly + Zeiler Inc.

ADDRESS 403 S. Wolfe St

Spec.—1-12-23—M&T—500 Blks.

E 58352

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58352

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 309 N Carrollton Ave (WARD) 16-24

2-FULL NAME Fannie M. Ely

(a) RESIDENCE NO. 309 N Carrollton Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced (HUSBAND of) WIFE of: Thomas Ely

6 DATE OF BIRTH (month, day, and year): May 5. 1866

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
64	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Essex Co Va

PARENTS

10 NAME OF FATHER: Henry Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Essex Co Va

12 MAIDEN NAME OF MOTHER: Agnes Stinnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Essex Co Va

14 Informant: Agnes Lucas

(Address): 309 N Carrollton Ave

15 7-1-1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1930

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to June 24 1930.

that I last saw her alive on June 24, 1930

and that death occurred, on the date stated above, at 3.15 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ..... yrs. mos 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) C. F. Revell M. D.

1930 (Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: June 27, 1930

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St.

Cor.—10-10-29—A Co.—100 Bks.

E 58353

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58353

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Lucy Hospital St. 23-34 Ward)

2-FULL NAME Thomas E Winkler

(a) RESIDENCE NO. 29 E Heath St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5 - 1904

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25	11	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Boiler Maker Helper
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Md. Pa. R.R. 23

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Winkler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Ullman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Anna Winkler
(Address) 29 E Heath St.

15 Filed JUL 7 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to Dec death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cut 3 3

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Hospital

Did operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) G E Slade, M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross C. C. Co — DATE OF BURIAL: June 28 1930

20 UNDERTAKER: Margaret E. Flynn — ADDRESS: 1422 Light St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58354

E 58354

CERTIFICATE OF DEATH.

89

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 Gittings Ave. ST. 27-45 WARD

2-FULL NAME August Ewalt Christhilf

(a) RESIDENCE NO. 401 Gittings Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Marsiliot

DATE OF BIRTH (month, day, and year) Oct. 28, 1872

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	57	7	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Consulting Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 30

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, (State or country) Md.

10 NAME OF FATHER Henry B. Christhilf

11 BIRTHPLACE OF FATHER (city or town) Balto., (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna M. O. Gill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Mrs. S. M. Christhilf

(Address) 200 Cedarcroft Road

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1925, to June 25 1930, that I last saw him alive on June 25, 1930, and that death occurred, on the date stated above, at 12 midnight.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) — yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Coronary Occlusion

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Lewis H. Gay, M. D.

, 19 (Address) 10 W. 54. Cons 54. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: June 28 1930

20 UNDERTAKER: John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl

Mitchell & Mitchell

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

201

E 58355

REGISTERED NO. E 58355

1-PLACE OF DEATH

City of Baltimore: (No. 6N Mercy Hosp St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~210 N. Exeter~~ S. Travers

(a) RESIDENCE NO. 271 N. Exeter St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	Col.	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
82			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer 0

9 BIRTHPLACE (city or town) [illegible]
(State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) [illegible]
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) [illegible]
(State or country)

14 Informant
(Address)

Filed JAN 27 1930 HAMILTON JONES, M. D. Registrar

By KLC

THE MORGUE 4775

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. fracture of back.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In at place of death

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. Burns, M. D.

Jan 26 1930 (Address) 1659 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL [illegible] 27 1930

ADDRESS

20 UNDERTAKER Commissioner Health.

UNIVERSITY OF MARYLAND

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58356

CERTIFICATE OF DEATH

66 E 58356

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. [illegible] St. 24-33 Ward

2-FULL NAME Peter Conklin

(a) RESIDENCE NO. 1443 Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	W	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	66			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 087
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed [illegible] 1930 HAMILTON JONES M. D. Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia hypostatic

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. T. [illegible], M. D.

Dec 16 1930 (Address) 1654 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL [illegible] 19

20 UNDERTAKER Commissioner Health

ADDRESS

UNIVERSITY OF MARYLAND

C.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58357. 31 E 58357.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. ..... ST. 16-21 WARD)

2-FULL NAME Milo Seabrook

(a) RESIDENCE NO. None ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 24, 1889

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	6		

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Macon
(State or country) Georgia

10 NAME OF FATHER William Seabrook

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Anna Stanford

13 BIRTHPLACE OF MOTHER (city or town) Macon
(State or country) Georgia

Informant Hospital Records
(Address)

Filed JUN 27 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to June 24, 1930,
that I last saw him alive on June 24, 1930,
and that death occurred, on the date stated above, at 4.15 p.m.
The CAUSE OF DEATH was as follows:

Pulmonary tuberculosis

(duration) Unknown mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) ..... M. D.
6-25-30 (Address) Baltimore City Hospitals

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND — DATE OF BURIAL JUN 27 1930

20 UNDERTAKER — ADDRESS

Commissioner of Health.

sec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58358 ✓ 100-08 E 58358

E 58358

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto. City Hospitals

CITY OF BALTIMORE: (No. 716-37 ST. WARD)

2-FULL NAME Edward Dailey

(a) RESIDENCE NO. Washington, D. C. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 weeks ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of -

DATE OF BIRTH (month, day, and year) April 28, 1862

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	1	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Charles Patrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky.

12 MAIDEN NAME OF MOTHER Mary Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

PARENTS

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23-30

17 I HEREBY CERTIFY, That I attended deceased from 5-20-30, 19, to 6-23-30, 19,

that I last saw him alive on 6-23-30, 19,

and that death occurred, on the date stated above, at 6:15 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cellulitis of leg

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Paul Padget, M. D.

6-23, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUN 27 1930

20 UNDERTAKER Commissioner Health

ADDRESS

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58359

CERTIFICATE OF DEATH

90 E 58359

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1801 N. Caroline ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia C. Muesse

(a) RESIDENCE NO. 1801 N. Caroline St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Fredericke Muesse

DATE OF BIRTH (month, day, and year) March 26, 1855

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	30 29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER J. H. Wittekindt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Martha Geiger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

Informant Miss Catherine Prechtel

(Address) 1732 N. Payson St.

Filed ... By ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jun 4, 1930, to Jun 25, 1930, that I last saw her alive on Jun 23, 1930, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Dilatation of heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) chron valvular disease

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John L Sanderson, M. D.

June 27, 1930 (Address) 1714 N. Caroline St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL June 28 1930

20 UNDERTAKER Joseph Block

ADDRESS 1003 West Baltimore St

...c.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58360 E 58360

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH Baltimore City Hospitals (T.B. 16-16)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy Carroll

(a) RESIDENCE NO. 916 W. Baltimore st. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 18, 1887

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	6	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horseshoer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER William Carroll

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Jennie Kennedy

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Maryland

Informant Hospital Records

(Address)

Filed 6-27-1930, 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to June 24, 1930,

that I last saw him alive on June 24, 1930,

and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos. Kennedy Jr. M. D.

6-24 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 6/27/1930

UNDERTAKER John J. Raby Sons

ADDRESS 318 Light St

Cor.—10-10-29—A Co.—100 Bks.

E 58361

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 58361

CERTIFICATE OF DEATH

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1726 Bolton St. 14-20 Ward)

2-FULL NAME Fred. C. Sucro

(a) RESIDENCE NO. 1726 Bolton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Asunta B. Sucro

6 DATE OF BIRTH (month, day and year) Oct 17-1873

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56	8	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman Mason
(b) General nature of industry, business, or establishment in which employed (or employer) Bragers 086
(c) Name of employer

9 BIRTHPLACE (city or town) Rochester N.Y.
(State or country)

PARENTS

10 NAME OF FATHER Jos. C. Sucro.

11 BIRTHPLACE OF FATHER (city or town) N.Y.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Wiesenberger

13 BIRTHPLACE OF MOTHER (city or town) N.Y.
(State or country)

14 Informant (Address) Mrs Jos. Sucro Baltimore.

15 Filed ..... 19.....

C. HAMPSON JONES, M. D. Registrar

JUN 7 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

mutral Stenosis

Sudden (duration) yrs. mos.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fred Falkenhan M. D. Coroner (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery

DATE OF BURIAL June 30 30

UNDERTAKER W. S. Marshall ADDRESS 3539 Fallsway

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58362

CERTIFICATE OF DEATH.

74-001

E 58362

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6203 Eversall Ave (St.) 27-42 (Ward)

2-FULL NAME Henry A. Spafford

(a) RESIDENCE NO. 6203 Eversall Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Carrie L. Spafford

6b DATE OF BIRTH (month, day, and year): Feb 7 1861

7 AGE — Years: 69 — Months: 4 — Days: — If LESS than 1 day, hrs. or min.:

8a OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Oil

(b) General nature of industry, business, or establishment in which employed (or employer): Lettie Carries

(c) Name of employer

8b BIRTHPLACE (City or town) (State or country): Milton Spafford Baltimore Md

PARENTS

10 NAME OF FATHER: Ireland

11 BIRTHPLACE OF FATHER (City or town) (State or country): Mary A. Lance

12 MAIDEN NAME OF MOTHER: Ireland

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Mrs Milton Spafford

14 Informant (Address): 6203 Eversall Ave

15 Filed ... 19 ... Registrar: C. HAMPSON JONES, M. D.

7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 5 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 5, 1930,

that I last saw h. alive on June 3, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1, ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. L. Lehman, M. D.

June 6 1930 (Address) 1301 N Rod-Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: June 28 1930

20 UNDERTAKER: A. S. Marshall

ADDRESS: 2330 Ell Rd

...c.—1-30—M. & T.—250 Blks.

E 58363 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58363

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home + Infirmary 30-69 46 REGISTERED NO.

CITY OF BALTIMORE: (No. Broadway + Fairmount Ave. WARD (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Webber Thorne

(a) RESIDENCE NO. 2211 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Phillip Henry Thorne

DATE OF BIRTH (month, day, and year) July 8, 1872 1873

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	11	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 57

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Hornell, N. Y. (State or country)

PARENTS

10 NAME OF FATHER John J. McGraw

11 BIRTHPLACE OF FATHER (city or town) Orland (State or country)

12 MAIDEN NAME OF MOTHER Mary Donohue

13 BIRTHPLACE OF MOTHER (city or town) Ontario, (State or country) Canada

14 Informant Louise Kirkmayer (Address) 761 Leonard Street

15 C. HAMPSON JONES, M. D. Registrar

7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to June 26, 1930, that I last saw her alive on June 26, 1930, and that death occurred, on the date stated above, at 12.33 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic cholecystitis + Carcinoma Uteri (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? ? at home.

Did an operation precede death? Yes Date of June 24, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A. J. E. Akelaitis, M. D.

19 (Address) Church Home + Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 6/28 1930

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert

Dec.—1-30—M. & T.—250 Blks.

E 58364 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58364

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2917 Woodland Ave. 27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marcellus Love

(a) RESIDENCE NO. 2917 Woodland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Love

DATE OF BIRTH (month, day, and year) Aug 10 1852

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	10	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER James L Love

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Robert L Love

(Address) 2917 Woodland Ave

Filed 7 1930 C. HAMPSON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1930

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1930, to June 27th, 1930

that I last saw him alive on June 27th, 1930

and that death occurred, on the date stated above, at 5.40 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A Rubert, M.D.

, 19 (Address) 478 X Gay St Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Park

DATE OF BURIAL June 30 1930

20 UNDERTAKER M. W. E. Deppel Inc

ADDRESS 31 S Calvert St

pec.—1-30—M. & T.—250 Blks.

E 58365 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58365

113

CERTIFICATE OF DEATH.

REGISTERED NO. 15-58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3940 Parkville Av. ST., WARD)

2-FULL NAME Dorothy Virginia Johnson

(a) RESIDENCE NO. 3940 Parkville Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 28 29

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto. (State or country) Md.

10 NAME OF FATHER Clarence E. Johnson

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Edna E. Lee

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Mrs Edna E. Johnson (Address) 3940 Parkville Av.

Filed 2 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26/30

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to June 26, 1930, that I last saw her alive on June 26th, 1930, and that death occurred, on the date stated above, at 11.50 a.m.

The CAUSE OF DEATH* was as follows:

Rachitic (from Digestive troubles

(duration) yrs. mos 2 1, ds.

CONTRIBUTORY (Secondary) Death accidental, Ignition of clothes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Smith, M. D.

6/26 1930 (Address) 1605 N. Monroe Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 28-1930
20 UNDERTAKER Horace H. Burgee	ADDRESS 363 Fallsway

spec.—1-30—M. & T.—250 Blks.

E 58366

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58366

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 319 Rossiter Ave ST. 16-27 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabell Mc Harry

(a) RESIDENCE NO. 614 Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Phillip W. McHarry

DATE OF BIRTH (month, day, and year) 4-20-1856

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
74		2	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Wm Jamison

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary J. McElroy

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs. C. Hampson Jones, M. D.

(Address) 319 Rossiter Ave

Filed 6-27-1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27/30

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1930, to June 27, 1930, that I last saw her alive on June 26, 1930, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. moe 5 ds.

CONTRIBUTORY (Secondary) Myocarditis chr.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Symptomatic

(Signed) Hiram Fried, M. D.

June 27, 1930 (Address) 316 Medical Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Cemetery

DATE OF BURIAL 6/28 1930

20 UNDERTAKER H. C. Manning Sons

ADDRESS 1136 Baltimore St.

1-30—M. & T.—100 B—50L

E 58367

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58367

CERTIFICATE OF DEATH

REGISTERED NO. 73

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Little Sisters of the Poor (Street) 16-14 (Ward)

2-FULL NAME Caroline Breitbach

(a) RESIDENCE NO Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Breitbach

6 DATE OF BIRTH (month, day, and year) Feb 10- 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	4	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Bissen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Probably Germany

12 MAIDEN NAME OF MOTHER Philamine Geibie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Probably Germany

14 Informant Little Sisters of Poor

(Address)

15 Filed 7-1930 C. HAMPSON JONES, M. D. Registrar

By ADH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25-30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure- Accidently fell in yard of her home(15 yrs ago) & injured spine

(duration) yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Hatten, M. D. Coroner

(Address) 508 E North Ave 6-27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 6/29/30

20 UNDERTAKER Mary E. Reilly

ADDRESS 1735 Hanover

Spec.—1-30—M. & T.—250 Bks.

E 58368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58368

REGISTERED NO. 154

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216-E. North Ave ST. 9-16 WARD)

2-FULL NAME Angela Bagwell

(a) RESIDENCE NO. 1620-N. Gay St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of None

DATE OF BIRTH (month, day, and year) 6/25/30

AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	—	—	2	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

8 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Harry E. Bagwell

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary L. Dudley

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Harry E. Bagwell

(Address) 1620-N. Gay St.

Filed 6-27-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-27-30

17 I HEREBY CERTIFY, That I attended deceased from 6-25-30, 19 to 6-27, 19 30.

that I last saw h alive on 6-26, 19 30,

and that death occurred on the date stated above, at p. m.

The CAUSE OF DEATH* was as follows: Premature Birth

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Congenital Heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lyda Rudley, M. D.

(Address) 1810 N. Gay St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 6/28/30 19

UNDERTAKER Mary T. Duffy Sons

ADDRESS 1735 Harford Ave

spec.—1-30—M. & T.—250 Blks

E 58369 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58369

CERTIFICATE OF DEATH. 31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2312 Herkimer St. 25-7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward James Horkey

(a) RESIDENCE NO. 2312 Herkimer St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Married

6 If married, widowed, or divorced (or) WIFE of Josephine M. Horkey

DATE OF BIRTH (month, day, and year) March 14, 1884

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	3	14	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R.R.

8 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER John Horkey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Josephine M. Horkey

(Address) 2312 Herkimer St.

15 Filed 7-1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/1161, 1930, to 6/26, 1930, that I last saw h[illegible] alive on 6/25, 1930, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm A Strauss, M. D.

6/26, 1930 (Address) 1901 Griffiss

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 6/30 1930

20 UNDERTAKER Frederick A. Cole — ADDRESS 1200 W. Fayette

...ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58370 | CERTIFICATE OF DEATH | 90 E 58370

REGISTERED NO. 15458

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3626 Reisterstown Rd. DIST. 15 (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Milton Peacock (White)

(a) RESIDENCE NO. 3626 Reisterstown Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 11 mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced (or) ~~WIFE of~~: Husband of Mrs Onette Peacock

DATE OF BIRTH (month, day, and year): July 8 - 1859

AGE: Years 71 | Months 11 | Days 18 | If LESS than 1 day, ...hrs. or ...min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Docket Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): City Courts

(c) Name of employer: State City

BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: Geo. W. Peacock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Ellen Scaling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Mrs Onette Peacock

(Address): 3626 Reisterstown Rd

15 Filed ..., 19... Registrar

6 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1930, to June 26, 1930, that I last saw him alive on June 26th, 1930 and that death occurred, on the date stated above, at 11:20 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary): Chronic Myocarditis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Physical Exams

(Signed) C. D. Gunor, M. D.

6-26 1930 (Address) 4936 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Front Royal, Va

DATE OF BURIAL: June 29 1930

20 UNDERTAKER: Wm J Tucker & Sons

ADDRESS: N. Y. Pa

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58371

CERTIFICATE OF DEATH.

129 E 58371

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Wilkins & Caton Aves) S. 14-59 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma Smith

(a) RESIDENCE No. 1333 N. North Ave Baltimore Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph P. Smith

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Gustave Klott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Diethrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Joseph Smith

(Address) 1333 N. North Ave Baltimore Md.

15 JUN 28 1930 . 19 NHA Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1930

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1930 . to June 26 . 1930 .

that I last saw h e alive on June 26 . 1930 .

and that death occurred, on the date stated above, at 1.30 a m. Standard time

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Ernest Spencer jr. M. D.

. 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL June 30, 30

UNDERTAKER Wm. H. Kirkner Sons ADDRESS Hotel Rd

sec.—1-30—M. & T.—250 Blks

E 58372

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 58372

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2716 Winchester ST. 16-68 (WARD)

2-FULL NAME Mary Stevens Godwin

(a) RESIDENCE NO. 2716 Winchester ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: John F. Godwin

7 DATE OF BIRTH (month, day, and year): May 15 - 1864

8 AGE — Years: 66 — Months: 1 — Days: 11 — If LESS than 1 day, ... hrs. or ..... min.

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): Work
(c) Name of employer: none

10 BIRTHPLACE (city or town) (State or country): Summit Co. Ohio

PARENTS

10 NAME OF FATHER: Samuel E. Rochester

11 BIRTHPLACE OF FATHER (city or town) (State or country): Summit Co. Ohio

12 MAIDEN NAME OF MOTHER: Sara McCleary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs. F. Godwin
(Address) 2716 Winchester St. Number

15 Filed ..... 19 ..... Registrar

8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1925 to June 26, 1930.

that I last saw h[illegible] alive on June 24, 1930.

and that death occurred, on the date stated above, at 9.45 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ✓ yrs. ✓ mos ✓ ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) John W. Graham M. D.

6/27, 1930 (Address) 1219 Gaylan Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 28 1930

UNDERTAKER: Wm J. Tuckner Sons — ADDRESS: N. Y. Pa.

spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58373 | CERTIFICATE OF DEATH. | 90 E 58373

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1423 Darley av ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Madeline Moxley

(a) RESIDENCE NO. 1423 Darley av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Moxley

DATE OF BIRTH (month, day, and year) Dec 5 1868

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	6	1	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer —

8 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Richards

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Carlson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Jas H Moxley 1423 Darley av

15 Filed 8 1930 — THAMPSON JONES, M. D. — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1930.

17 I HEREBY CERTIFY, That I attended deceased from January 25, 1930, to June 26, 1930, that I last saw her alive on June 25, 1930, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Cystitis

Instantaneous

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) Albert Simonds, M. D.

June 27, 1930 (Address) 16 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem — DATE OF BURIAL: June 28 19

UNDERTAKER: W. J. Sudbury & Son — ADDRESS: Md

pec.—1-30—M. & T.—250 Bks

E 58374

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58374

CERTIFICATE OF DEATH.

X 60-001

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (NO. ..... ST. 12-44 (Lane)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. John J. Reilly (Helen)

(a) RESIDENCE NO. 40 Broad St., Harrisonburg, Va. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6 If married, widowed, or divorced (or) WIFE of John J. Reilly

DATE OF BIRTH (month, day, and year) Jan. 26, 1886

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44	5	2	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Parkersburg, W. Va.

PARENTS

10 NAME OF FATHER Michael McGrail

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Mulvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wheeling W. Va.

14 Informant Hospital Records
(Address)

15 6-28-1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/28/30

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1930, to June 28, 1930, that I last saw him alive on June 27, 1930, and that death occurred, on the date stated above, at 5:00 a.m. (Daylight Saving Time)

The CAUSE OF DEATH* was as follows:

Exopthalmic goitre

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertheroidism

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 6/26/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) M. F. Bixler, M. D.

6/28, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrisonburg Va. DATE OF BURIAL June 28 1930

20 UNDERTAKER Geo. F. Jenkins & Son ADDRESS Clerk Harrisonburg

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58375 E 58375

CERTIFICATE OF DEATH

128

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 S Charles ST. 23-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine M. Connor

(a) RESIDENCE NO. 1215 S. Charles ST. 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Connor

DATE OF BIRTH (month, day, and year) July 1869

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	11		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Frederick Stage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not given

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Connor

(Address) 1215 S. Charles St

15 Filed 6/28, 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26th, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 15th, 1930, to June 26th, 1930, that I last saw h.. alive on June 26th, 1930 and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis following

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. — mos. 6 hours

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Harry Weinberg, M. D.

6/27, 1930 (Address) 1324-26 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 30 1930
20 UNDERTAKER	ADDRESS
Fred A. Kramer & Son	703 Hanover St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58376 + 90 ✓ E 58376

E 58376

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 918 Aisquith ST. 10-14 WARD)

2—FULL NAME Hattie Flowers.

(a) RESIDENCE NO. 918 Aisquith ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Flowers

DATE OF BIRTH (month, day, and year): March 1877

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	51	3		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hairdresser

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Richmond Va.

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Walter Flowers (Address) 918 Aisquith St.

15 Filed JUN 28 1930 C. HAMPSON JONES, M. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26-1930

17 I HEREBY CERTIFY That I attended deceased from Apr. 11, 1930, to June 25, 1930, that I last saw her alive on June 25, 1930 and that death occurred, on the date stated above, at 5.05 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy. Exam.

(Signed) W. S. Taylor, M. D.

19 (Address) 1522 Harlem Ave. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem. DATE OF BURIAL: June 28 1930

20 UNDERTAKER: Chas. H. Johnson 416 N. ADDRESS: Caroline St.

pec.—1-30—M. & T.—250 Blks

E 58377

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58377

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Cold Spring Lane St. 27 WARD) 27-56

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Stone Sims

(a) RESIDENCE NO. 1402 Cold Spring Lane St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Infant

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) June 27-1930

AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
				6

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank L. Sims

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Edith L. Stone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Frank L. Sims

(Address) 1402 Cold Spring Lane

15 Filed JUN 28 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 30

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1930, to June 27, 1930, that I last saw h... alive on June 27, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank L Simms, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Mem.

DATE OF BURIAL June 28 1930

20 UNDERTAKER George W Zipkin

ADDRESS 1737 E. Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58378

CERTIFICATE OF DEATH.

74-001

REGISTERED No. E 58378

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3610 E. Hamilton 21-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Elizabeth Blankenes

(Residence in Baltimore: No. 1021 Russell St St.; 47 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH, Aug (Month) 27 (Day), 1859 (Year)

7-AGE, 70 yrs. 10 mos. 0 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Own

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Unknown Fuller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Reitemeyer

(Address) 3610 E. Hamilton Ave

15- C. HAMILTON JONES, M. D.

No 28 1930 1931 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 27 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 24 1930 to June 27 1930, that I saw h[illegible] alive on June 27 1930, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mon. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(Duration) yrs. mos. ds.

(Signed) Geo. L. Jones M. D.

June 27, 1930 Address 5631 Harford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cem

DATE OF BURIAL, June 30, 1930

20-UNDERTAKER Phelps Herwig

ADDRESS 2016 Orleans St

Spec.—1-30—M. & T.—250 Blks.

2D 8194 58379 HEALTH DEPARTMENT—CITY OF BALTIMORE X 135 E 58379

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 7-9 WARD)

2-FULL NAME Juan Read

(a) RESIDENCE No. San Domingo ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

6 If married, widowed, or divorced (a) HUSBAND of (or) WIFE of unknown

7 DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) San Domingo

PARENTS

10 NAME OF FATHER Wm Read

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-27-30

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to June 27, 1930, that I last saw him alive on June 27, 1930, and that death occurred, on the date stated above, at 11 50 P m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 2 yrs. mos da.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1/2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 27, '30.

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) E C Jones, M. D.

, 19 (Address) John Hopk Hosp Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York & N Y. DATE OF BURIAL June 28, 1930

UNDERTAKER Geo M. Frick & Son ADDRESS 811 Wolfe

...c.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58380

CERTIFICATE OF DEATH

129

E 58380

REGISTERED NO.....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1460 Reynolds ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ANNA ELIZABETH SCHWANKE

(a) RESIDENCE NO. 1460 Reynolds ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelm Schwanke

DATE OF BIRTH (month, day, and year) Feb. 19, 1868

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	62	4	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Conrad Voelker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. Carrie Clarke (Daughter)

(Address) 1460 Reynolds St.

Filed 6-28-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to June 26, 1930, that I last saw her alive on June 24, 1930, and that death occurred, on the date stated above, at 4.00 P. m.

The CAUSE OF DEATH* was as follows: Acute cardiac dilatation

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hopkinson, M. D.

6/28, 1930 (Address) 1 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul's Cemetery

DATE OF BURIAL June 30, 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore St. & Broadway.

ec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58381

CERTIFICATE OF DEATH

100-81

E 58381

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2836 Hudson ST. 1-1 WARD)

2—FULL NAME Hildegard Missel

(a) RESIDENCE NO. 2836 Hudson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ds. How long in U. S., if foreign birth? 50 yrs. ? mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of William N. Missel.

DATE OF BIRTH (month, day, and year) May 3, 1853

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	1	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Herman Doerschell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant William Missel (Son)

(Address) 2836 Hudson St.

15 Filed JUN 30 1930 19 Registrar C. HAMPSON JONES, M. D.

81930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1930, to June 26, 1930, that I last saw her alive on June 26, 1930 and that death occurred, on the date stated above, at 11 15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence.

(Signed) Geo. B. Dyhert, M. D.

19 (Address) 2802 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery

DATE OF BURIAL: June 27 1930

20 UNDERTAKER: Henry Sauter & Sons. Inc.

ADDRESS: Baltimore St. & Broadway.

spec.—1-30—M. & T.—250 Blks.

~~37959~~ 58382 HEALTH DEPARTMENT—CITY OF BALTIMORE ~~37959~~ E 58382

CERTIFICATE OF DEATH. X 135

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 9-9 WARD)

2-FULL NAME Peter Brooks

(a) RESIDENCE NO. Olivet Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	Black	Unknown.

6 If married, widowed, or divorced HUSBAND of or) WIFE of

7 DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 056

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Car

PARENTS

10 NAME OF FATHER Isaac

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lena Parun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed JUL 8 1930, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June - 28-30

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1930, to June 28, 1930, that I last saw him alive on June 28, 1930, and that death occurred, on the date stated above, at 1.55 p. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia. Uraemia.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 20, 1930.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Geo Lamar, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Eastern Cem Balto Co. 30 1930

DATE OF BURIAL

20 UNDERTAKER E. H. Barker

ADDRESS 47 Washington

spec.—1-30—M. & T.—250 Blks.

E 58383 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58383

CERTIFICATE OF DEATH.

124

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 16-68 W.)

2-FULL NAME Paul Tookes

(a) RESIDENCE NO. 2850 Harlem Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White Italian	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Mary Tookes

7 DATE OF BIRTH (month, day, and year) June 27, 1892

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
38				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer Owner

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Phillip Tookes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant John M. Danza (Address) 4204 E. 22nd St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 - 1930

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1930, to June 27, 1930, that I last saw him alive on June 27, 1930, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Cholecystitis (Chronic)

Pyloric Stenosis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Post-operative shock, Cardiac failure (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/25/30 Cholecystotomy

Was there an autopsy? No

What test confirmed diagnosis? History, T.C. clay signs symptoms operation

(Signed) W. Glenn Speicher M. D.

6/27 1930 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL June 30, 1930

20 UNDERTAKER Frank V. Pipitone — ADDRESS 218 S. Eutaw

6-1930 C. HAMILTON INNIS, M. D. Registrar

pec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58384

CERTIFICATE OF DEATH

40 E 58384

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2134 E. Federal ST. 8-16 WARD)

2—FULL NAME Margaret C Renner

(a) RESIDENCE NO. 2134 E Federal St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 9 mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Otto Renner

DATE OF BIRTH (month, day, and year) Sept 28 1883

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	9	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) at home 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Charles J Yensch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Laura Spangler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Mr Charles J Yensch

(Address) 2134 E Federal st

Filed 6-28-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25/1930

17 I HEREBY CERTIFY, That I attended deceased from 6/1, 1930, to 6/25, 1930, that I last saw her alive on 6/25, 1930 and that death occurred, on the date stated above, at 1130 S.T. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation (duration) 17 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) Dand Neely, M. D.

6/26 1930 (Address) 1500 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	June 28 1930
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

pec.—1-30—M. & T.—250 Bks.

E 58385 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58385

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fruitrity Hosp. ST. 14-24 (WARD)

2-FULL NAME Florence Schmidt.

(a) RESIDENCE NO. 309 S. Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	M.

6 If married, widowed, or divorced HUSBAND of or) WIFE of Henry Schmidt.

7 DATE OF BIRTH (month, day, and year) May 11 1885

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	1	14 15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Richard Schriever

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Elizabeth Reilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mr. Henry Schmidt

(Address) 309 S Woodyear st

15 Filed 8 1930 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26/30.

17 I HEREBY CERTIFY, That I attended deceased from 6/17, 1930, to 6/26, 1930, that I last saw her alive on 6/26, 1930, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis without edema.

(duration) intermm. yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia. (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & laboratory.

(Signed) Henry J. Merril, M. D.

6/25, 1930 (Address) Fruitrity Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL June 30,

20 UNDERTAKER John F Denny — ADDRESS 715 Lisbon St

pec.—1-30—M. & T.—250 Blks

E 58386 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58386

CERTIFICATE OF DEATH. X 74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward O. Weant

(a) RESIDENCE NO. Westminister. Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. one da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

6 If married, widowed, or divorced HUSBAND of (or WIFE of) Virginia Weant

7 DATE OF BIRTH (month, day, and year) Nov. 28-1869

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	7		

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney-at-Law.

(b) General nature of industry, business, or establishment in which employed (or employer) Law. 0+2

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Carroll County Maryland.

PARENTS

10 NAME OF FATHER J. Washington Weant.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Hannah Millar.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Virginia Weant (Wife)

(Address) Westminster. Md.

15 Filed 8-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1930, to June 28, 1930, that I last saw him alive on June 27, 1930, and that death occurred, on the date stated above, at 7 10 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

(duration) 1 yrs. mos da.

CONTRIBUTORY (Secondary) Hemorrhage in left Cerebellum (duration) yrs. 18 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Edward Bayley Jr., M. D.

, 19 (Address) Lafayette Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Carroll Co Md	June 28 1930
20 UNDERTAKER Henry O. Jenkins Sons Co	ADDRESS Orchard & McCulloh St

1-30—M. & T.—100 B—50L

E 58387

HEALTH DEPARTMENT—CITY OF BALTIMORE

52 E 58387

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 2-4 WARD)

2-FULL NAME Catherine Hoey

(a) RESIDENCE NO 2033 Gough ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick J. Hoey

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Richard Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas Hoey (son)
(Address) 2033 Gough St

15 Filed 6/28, 1930 C. HAMPSON JONES, M. D., Registrar

8 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
(Arteriosclerosis)
(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) "History Rheumatism & Neuritis" (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John A. Allen, M. D.
Coroner

6/28/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL June 30, 1930

20 UNDERTAKER John A. Moran — ADDRESS 3000 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

E 58388

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58388

CERTIFICATE OF DEATH.

X 148

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) Perkins & Eaton Avenues (WARD) 25-22

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Gibson

(a) RESIDENCE NO. 22 Link Ave ST., Halethorp WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Edwen O. Gibson

6 DATE OF BIRTH (month, day, and year) May 10th 1889

7 AGE: 41 Years, 1 Months, 17 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework.

(b) General nature of industry, business, or establishment in which employed (or employer): /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER James D Marquess

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Molly Burkehead

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant Mr Edwin Gibson

(Address) 22 Link Ave Halethorp Md

15 8 1930 C. HAMPSON JONES, M. D. (19) Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27th 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1930, to June 27, 1930, that I last saw h alive on June 27, 1930, and that death occurred, on the date stated above, at 11-5 a m. Standard time

The CAUSE OF DEATH* was as follows:

Nephritic Toxemia - Pregnancy

Acute Nephritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Caesarean Operation - Post Operation Shock (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes No Date of 6/27/30

Was there an autopsy?

What test confirmed diagnosis? Physical Signs

(Signed) W. S. Lawson, M. D.

19 (Address) Halethorpe, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: June 30 1930

UNDERTAKER: John J Howard & Son ADDRESS: 901 Holliday St.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002 E 58389

CERTIFICATE OF DEATH

E 58389

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Wyeth St. ST., 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Marie Ruby

(a) RESIDENCE NO. 606 Wyeth St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) June 27 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto. Md.
(State or country)

10 NAME OF FATHER Charles A. Ruby

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Anna Flathman

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Mr. Ruby

(Address) 606 Wyeth St.

Filed 6 29 1930 15 HAR[illegible] JONES M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/28/30

17 I HEREBY CERTIFY, That I attended deceased from 6/27 30, to 6/28 30, that I last saw h[illegible] alive on 6/28 30, and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hemorrhage of vagina + Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luther Dorsey, M. D.

19 (Address) 1327 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 6/30 1930

20 UNDERTAKER J. Frew McCully

ADDRESS 130 E Fort

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58390

58390

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) Wilkins & Caton Avenues (WARD) 25-7K

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Mills

(a) RESIDENCE No. 2708 Gwynn Oak Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine O. Wills

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Not obtainable

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Not obtainable

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Frank Mills
(Address) 2705 Gwynn Oak Ave

15 Filed 6 29 1930 C. HAMPSON MYERS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/28 1930.

17 I HEREBY CERTIFY, That I attended deceased from 6-1 .1930. to 6-28 .1930.
that I last saw him alive on 6-28 .1930.
and that death occurred, on the date stated above, at 1 25 a.m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory. Xrays

(Signed) Robert Heuer, M. D.
, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 7/1 1930

20 UNDERTAKER Hendrey & Myers and Sons

ADDRESS N. Calvert

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 E 58391

58391

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Abbott ST. 7-13 WARD)

2-FULL NAME Helen E Sunkett

(a) RESIDENCE NO. 1614 Abbott ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Sunkett

6 DATE OF BIRTH (month, day, and year) May 17 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Chas Edw. Hersog

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Maggie Shepherd

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Harry Sunkett (Address) 1614 Abbott st

15 Filed JUN 28 1930 H. HANSON JONES, M. D. Registrar per Kelly

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1930

17 I HEREBY CERTIFY, That I attended deceased from April, 19 30, to June 26, 19 30, that I last saw h. alive on June 25, 19 30, and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix uteri

(duration) yrs. 4 mos. da.

CONTRIBUTORY (Secondary) Generalize Carcinoma of Pelvis and Bladder (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical

(Signed) R. J. Gorter, M. D.

6/28, 1930 (Address) 1424 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem. DATE OF BURIAL 6-29 1930

20 UNDERTAKER Byron & Wright 1218 N. Eutaw St ADDRESS

pec.—1-30—M. & T.—250 Bks

E 58392

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 58392

REGISTERED NO.

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST. 17-24 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Mary Elizabeth Johnson

(a) RESIDENCE NO. 1137 Etting St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

7 DATE OF BIRTH (month, day, and year): 1861

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

10 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address): Balto. City Hosp.

15 6-29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-26-30

17 I HEREBY CERTIFY, That I attended deceased from 9-3-21, 19..., to 6-26-30, 19..., that I last saw her alive on 6-26-30, 19..., and that death occurred, on the date stated above, at 7:35 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic + acute.

(duration) 9 yrs. mos. da.

CONTRIBUTORY (Secondary): Arteriosclerosis.

(duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padget, M. D.

6-28 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Home

DATE OF BURIAL: 6-30

20 UNDERTAKER: John W. Kline Hm

ADDRESS: Woodlawn

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58393

E 58393

CERTIFICATE OF DEATH

17°

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 9-11 WARD)

2-FULL NAME Minerva Hall

(a) RESIDENCE NO 1569 Homestead ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Vernon Hall

6 DATE OF BIRTH (month, day, and year) Aug 10-1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22	10	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Walter Howe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Minnie Melvin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant A. V. Hall

(Address) 1569 [illegible] Homestead St

15 Filed ..... 1930 C. HAMPSON JONES, M.D. Registrar

N 29 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Infectous Pneumonia- Rifle shot wound left lung-June 22/30
Suicide

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. S. H. Collins, M. D.
Coroner

6/28/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL June 30 19 30

UNDERTAKER Henry Lutz

ADDRESS 1203 Broadway

1-30—M. & T.—100 B—50L

E 58394

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58394

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Mem. Hos ST. 12-49 (WARD)

2-FULL NAME Everett S. Fender

(a) RESIDENCE NO Belair Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept-26-1915 (Inquest)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	14	9	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa Belair Md

PARENTS

10 NAME OF FATHER J. D. Fender

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Martha Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant D. Fender
(Address) Belair Md

15 Filed 6-29-1930 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down by auto while walking along Road

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Churchville Rd nr Belair

Did an operation precede death? Yes Date of 6/29/30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Surgical

(Signed) J. J. Frame M. D. Coroner

6/29, 1930 (Address) 2939 N. Eldon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion M E — DATE OF BURIAL July 1 1930

20 UNDERTAKER Deans & Jutte — ADDRESS Belair Md

Spec.—1-30—M. & T.—250 Blm.

E 58395 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58395

63

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1109 Bolton St. 11-24 WARD)

2-FULL NAME Allen W. Wagner

(a) RESIDENCE NO. 1109 Bolton St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced. HUSBAND of or) WIFE of: Harriett Wagner

6 DATE OF BIRTH (month, day, and year): Aug- 9-1890

7 AGE: 39 — Years: 40 — Months: 10 — Days: 17 — If LESS than 1 day, ... hrs. or ..... min.

8a OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Chauffer
(b) General nature of industry, business, or establishment in which employed (or employer): 023
(c) Name of employer: 1

9 BIRTHPLACE (city or town) (State or country): Penn

PARENTS

10 NAME OF FATHER: Walter Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn

12 MAIDEN NAME OF MOTHER: Lidy Grimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn

14 Informant (Address): Harriett Wagner. 1109 Bolton St

15 Filed JUN 29 1930 HAMPTON MORRIS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1930

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1930 to June 26, 1930 that I last saw h[illegible] alive on June 26, 1930 and that death occurred, on the date stated above, at 2-40 P.M.

The CAUSE OF DEATH* was as follows:

Addison Disease.

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Anemia.

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? X-ray, Blood & Faeces

(Signed) James E. Cowie, M. D.

June 28, 1930 (Address) La Roche Apt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL 6/29 1930

20 UNDERTAKER: Samuel Hemsley ADDRESS 1128 N Bolton

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58396

167-001

E 58396

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1207 East North Ave. St., 9-18 (Ward)

2-FULL NAME Samuel H. Nachman

(a) RESIDENCE NO. 1207 East North Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna M. Nachman

6 DATE OF BIRTH (month, day, and year) March 17, 1865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	65	3	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER Henry Nachman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mina Hayman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Sondheim Records
(Address) 1902 Eutaw Place

Filed 2 9 1930 19 C. HAROLD JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28th. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphiziation-
Suicide.
Seated himself before small gas
heating stove in cellar with
coat over head.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. S. H. Baer M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oheb Shalom Cem.

DATE OF BURIAL 6/30/ 19 30

20 UNDERTAKER Abrid. Sondheim & Son

ADDRESS 1902 Eutaw Place

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

✓ & 58397

No. 58397 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 60-001 P. [redacted]

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 14-30 ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie Green

(a) RESIDENCE NO. New Windsor, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

6a If married, widowed, or divorced ~~HUSBAND of~~ or WIFE of: John Green,

6 DATE OF BIRTH (month, day, and year): 1876

7 AGE: Years: 54; Months: 7; Days: 3; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Charles Bangs.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Emma Bart.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: John Green

(Address): R. F. D. New Windsor, Md.

JUN 29 1930 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29-1930

17 I HEREBY CERTIFY, That I attended deceased from June 10-, 1930, to June 29-, 1930,

that I last saw h.. alive on June 29-, 1930,

and that death occurred, on the date stated above, at 8 : P. m.

The CAUSE OF DEATH* was as follows:

Toxic Goitre

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary): Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of June 25-1930

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs + symptoms

(Signed) M. C. Carlefleur, M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Carroll Co. Md. Pipe Creek Cemetery

DATE OF BURIAL: July 2-1930

20 UNDERTAKER: C. M. Waltz

ADDRESS: Winfield, Md.

Spec.—1-30—M. & T.—250 Bks

E. 58398

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C 58398

129 [illegible]

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) CITY OF BALTIMORE) (No. 3408 Elgin ave ST., 15-61 WARD)

2-FULL NAME James Augustus Bealmear

(a) RESIDENCE NO. 3408 Elgin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary T. Bealmear

6 DATE OF BIRTH (month, day, and year) Sept 2" 1842

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
87	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estater

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Bealmear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Frances Brewer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Cleveland Bealmear (Address) 3408 Elgin ave

15 Filed JUN 30 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27/1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to June 27, 1930, that I last saw him alive on June 27, 1930, and that death occurred, on the date stated above, at 720 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis about (duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocarditis about (duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical + Laboratory

(Signed) W S Tublett, M. D.

6/30/30 (Address) 2220 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Jun 30 1930

20 UNDERTAKER W. J. Gruver & Son — ADDRESS North

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58399

CERTIFICATE OF DEATH.

113 E 58399

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO.) 619 S. Bethel ST. 2-4 (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chester. Barzal.

(a) RESIDENCE NO. 619. S. Bethel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 4- 1929
7 AGE — Years: — Months: 9 — Days: 25. 24 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS
10 NAME OF FATHER Stanley. Barzal
11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland
12 MAIDEN NAME OF MOTHER Mary Ramsey
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanley. Barzal
(Address) 619 S Bethel St.

15 Filed JUN 30 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28. 30

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1930, to June 28, 1930,
that I last saw him alive on June 28, 1930,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 2 ds.
CONTRIBUTORY (Secondary) Cardiac Paralysis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Wilbur Myers M. D.
June 28 1930 (Address) 801 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary
DATE OF BURIAL: 6/30 1930
(UNDERTAKER) John Fiedkowski ADDRESS 1618 Eastern

...ec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58400

CERTIFICATE OF DEATH

90 ✓

E 58400

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3101 Elliott ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosina M. Hackmann

(a) RESIDENCE NO. 3101 Elliott ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

DATE OF BIRTH (month, day, and year) Oct 23 1857

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	72	8	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Casper Krempp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Koehler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Ida Ambeau

(Address) 1 Bristol Ave

15 Filed 3 0 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 26, 1930, that I last saw her alive on June 26, 1930 and that death occurred, on the date stated above, at 8.55 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Gradual

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Gradual

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Zellers, M. D.

6/26, 1930 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL June 30 1930

20 UNDERTAKER John G. Connelly ADDRESS Essex

Spec—12-23-21—E.B.R.S.—400 Bks.

Dashields

58401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 58401

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 206 W. Hamburg St. 22-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mary Dashields

(a) Residence No... 206 W. Hamburg St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 1872

7-AGE. 58 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... at Home

(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Closey

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah A. Handy

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md

14-

(Informant) Sarah Collins

(Address) 206 W. Hamburg St

15-Filed JUN 30 1930, HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 27 1930

17- I HEREBY CERTIFY, That I attended deceased from May 27, 1930, to June 27, 1930

that I last saw h[illegible] alive on June 27, 1930

and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

.....(Duration).....yrs. 1 mos.....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

.....(Duration).....yrs. 1 mos.....ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Observation and Symptoms

(Signed) [illegible] M. D.

June 2, 1930 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-CREMATION, REMOVAL, [illegible] DATE OF BURIAL, July 1, 1930

20-UNDERTAKER, John H. Jordan ADDRESS 1627 Aisquith

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58402

E 58402

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1817 N. Port ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Gordon

(a) RESIDENCE NO. 1817 N. Port ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Daniel C.

6 DATE OF BIRTH (month, day, and year): Jan 29th 1846

7 AGE: Years 84 | Months 4 | Days 29 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Thomas Finley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs Elizabeth Blakeney

(Address) 1817 N. Port St

15 Filed 3 0 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to June 28, 1930, that I last saw her alive on June 28, 1930, and that death occurred, on the date stated above, at 1055 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arterial Hypertension

Arteriosclerosis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Apoplexy and Uraemia

(duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert Abrams, M. D.

6/30 1930 (Address) 2025 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: July 1st 1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks

Dr Hawkins's
Chas. & Randall

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58403

CERTIFICATE OF DEATH.

90 E 58403

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 113 S. Arlington ST., 16 WARD

2-FULL NAME Katherine M. Curtis

(a) RESIDENCE NO. 113 S. Arlington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Aaron Curtis

7 DATE OF BIRTH (month, day, and year): Dec 29th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	5	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home 037
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: Henry Sims
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Katharine Hook
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Aaron Curtis
(Address): 113 South Arlington

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27-1930

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to June 27, 1930,
that I last saw h[illegible] alive on June 26, 1930,
and that death occurred, on the date stated above, at 5:45 p. m.

The CAUSE OF DEATH[a] was as follows:

Acute Cardiac dilatation

CONTRIBUTORY (Secondary) Senile Myocarditis (duration) ..... yrs. ..... mos. 5 ds.

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. F. Hawkins M. D.
6/28 1930 (Address) 1 E Randall St

[a]State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery
DATE OF BURIAL: 6/30 1930

20 UNDERTAKER: Merriam Cook
ADDRESS: 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks

Dr Nelson
1001 N. Fulton

HEALTH DEPARTMENT—CITY OF BALTIMORE

58404 E. 58404

CERTIFICATE OF DEATH.

57

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1132 North Fulton Ave ST., 22 WARD)

2-FULL NAME Julia A. Myers

(a) RESIDENCE NO. 1132 North Fulton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob H. Myers

7 DATE OF BIRTH (month, day, and year): April 11 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	2	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Carroll Co Maryland

PARENTS
10 NAME OF FATHER: Jesse Butler
11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co Maryland
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Co Md

14 Informant (Address): Jacob H. Myers 1132 N. Fulton Ave

15 Filed JUN 30 1930 C. HANSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29-1930

17 I HEREBY CERTIFY, That I attended deceased from May 1- 1930, to June 29, 1930,
that I last saw h[illegible] alive on June 29, 1930,
and that death occurred, on the date stated above, at 530a m.

The CAUSE OF DEATH* was as follows:
Diabetic Coma -
(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 8 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Blood
(Signed) J. Thomas Nelson, M. D.
1930 (Address) 1001 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lingamore Chapel Cem Frdk Co
DATE OF BURIAL: 7/1 1930

20 UNDERTAKER: Williams Corbin
ADDRESS: 1217 St Paul

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

58405

CERTIFICATE OF DEATH.

E 58405

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5716 York Rd St. 27-48 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William B. Foudray

(a) RESIDENCE No. 5716 York Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
M	W	Married

6a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Louise Foudray.

6 DATE OF BIRTH (month, day, and year) Jan 27th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm B Foudray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Julia Frederick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs G M Cox

(Address) 5815 Halwyn Ave

Filed JUN 30 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29th 1930

17 I HEREBY CERTIFY, That I attended deceased from July- 1924- to June 29 1930, that I last saw him alive on June 28 1930, and that death occurred, on the date stated above, at 3.25 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H E Hoes, M. D.

6-29, 1930 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gorsuch Pres Cem	July 1 1930
UNDERTAKER William Cook	ADDRESS 1217 N Paul St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 **E 58406**

E 58406

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST., 10-14 WARD)

2-FULL NAME Annie Kretz

(a) RESIDENCE NO. 1207 Ashland Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND) of (or) WIFE of: Single

6b DATE OF BIRTH (month, day, and year): Sep. 9 1866

7 AGE: 63 Years 64 | 9 Months Unknown | Days 14 | If LESS than 1 day.....hrs. or.....min.

8a OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper 067

(b) General nature of industry, business, or establishment in which employed (or employer): Bakery

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Kretz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bavaria

12 MAIDEN NAME OF MOTHER: Frances Betz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bavaria

14 Informant (Address): Mt Hope Friends Mt Hope Retreat

15 Filed ..... 19 ..... C. HARRISON JONES, M. D., Registrar.

JUN 30 1930 Mar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to June 27, 1930, that I last saw her alive on June 27, 1930, and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Cardiac Insufficiency)

Sudden (duration) ..... yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Manic - Depressive Psychosis (duration) — yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hall, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: July 1 1930

20 UNDERTAKER: Frank A. Fink — ADDRESS: 910 N. Gay

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58407.

CERTIFICATE OF DEATH

REGISTERED NO. E 58407.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5304 Bellville Ave. 28-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter P. McComas

(a) RESIDENCE NO. 5304 Bellville Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel R. McComas,

6 DATE OF BIRTH (month, day, and year) April 18, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Mabel R. McComas (Address) 5304 Bellville Ave.

15 6-30-1930 A. M. JONES, M. D. Residence

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUN 28 1930

17 I HEREBY CERTIFY That I attended deceased from Sept, 1924 to June 28, 1930 that I last saw h[illegible] alive on June 28, 1930 and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulm. tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Microscopecally

(Signed) Thos. Dugan Thomas, M. D.

6/30 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL JUL 1 1930

20 UNDERTAKER Geo N Little

ADDRESS 2700 EDMONDSON AVE.

Spec.—1-30—M. & T.—250 Bks.

58408 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58408

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2116 Oake (ST.) 12-51 (WARD)

2-FULL NAME Spencer M. Nash Sr

(a) RESIDENCE NO. 2116 Oake ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	b	M

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah E. Nash

6 DATE OF BIRTH (month, day, and year) Dec 24 - 89

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Dorsey Nash

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Emma Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Sarah E. Nash
(Address) 2116 Oake St.

15 [illegible] 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28/30

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to June 28, 1930, that I last saw him alive on June 27, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary): [illegible]
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pittelson, M. D.

, 19 (Address) 817 Hamilton Terr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 7-1-1930

20 UNDERTAKER: Jno. W. Chase — ADDRESS: New 400 Mosher

Spec.—1-30—M. & T.—250 Blks

Pauline Beckman

E 58409 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 58409

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST. 21-24 WARD)

2-FULL NAME Pauline Beckman

(a) RESIDENCE NO. 716 McHenry St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman

6 DATE OF BIRTH (month, day, and year) May 14, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Louis Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Matilda Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Records of Balto. City Hosp.

15 Filed JUN 30 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-26-30

17 I HEREBY CERTIFY, That I attended deceased from 6-23-30, 19..., to 6-26-30, 19..., that I last saw her alive on 6-26-30, 19..., and that death occurred, on the date stated above, at 10:50 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis, chronic, rheumatic

More than 3 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) Myocarditis, chronic + acute (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

6-27 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon P K

DATE OF BURIAL 6/30/30

20 UNDERTAKER Chas Lembuch

ADDRESS 1-24 Aisquith St

Spec.—1-30—M. & T.—250 Blks.

E 58410 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58410

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital 4-31 (ST., WARD)

CITY OF BALTIMORE: (NO.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rachael Walker

(a) RESIDENCE NO. Hampstead Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (Husband or) WIFE of William Walker

6 DATE OF BIRTH (month, day, and year) Feb 7 1870

7 AGE: Years 59 | Months 9 | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Own home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Randolph Leatherwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Leslie Lipps
(Address) Hampstead Md

15 Filed 6-30-1930 H. LIPSCOMB LOWES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29-1930

17 I HEREBY CERTIFY, That I attended deceased from June 19- 1930 to June 29 1930, that I last saw h-s- alive on June 29 1930, and that death occurred, on the date stated above, at 5:10 p. m.

The CAUSE OF DEATH* was as follows:
Toxic goitre.
Hypertension.
Arteria sclerosis - Generalized.
(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Myocardial failure.
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home (Private residence)
Did an operation precede death? Yes Date of June 28-1930
Was there an autopsy? No.
What test confirmed diagnosis? Typical signs + symptoms

(Signed) Jno H. Yeager, M. D.
6/29, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount, Md
DATE OF BURIAL July 2 1930

20 UNDERTAKER Edw Tipton
ADDRESS Hampstead Md

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58411 — CERTIFICATE OF DEATH — 161-001 — E 58411

1—PLACE OF DEATH Provident Hospital — REGISTERED NO. _____

CITY OF BALTIMORE: (No. 1514 Division ST. 9th WARD) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME (Infant) Thomas

(a) RESIDENCE NO. 624 E. 28th ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21st 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Provident Hosp.

PARENTS

10 NAME OF FATHER Albert Edward Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ethel Anna Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant mother

(Address)

15 Filed JUN 30 1930 19 C. HANSON JONES, M. D. Registrar

By _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21st 1930

17 I HEREBY CERTIFY, That I attended deceased from June 21st, 19 30, to June 21st, 19 30, that I last saw h[illegible] alive on June 21st, 19 30 and that death occurred, on the date stated above, at 10 10 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity (5½ - 6 months)

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Butler, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Retained for Laboratory purposes.

DATE OF BURIAL _____ 19

20 UNDERTAKER _____

ADDRESS _____

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58412

E 58412

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (No. ..... ST., 11-24 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Weeks

(a) RESIDENCE NO. 442 Orchard st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1908

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22			

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

8 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Kalif Weeks

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Allen

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1930, to June 26, 1930,

that I last saw him alive on June 26, 1930,

and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jas. Arnold Jr. M. D.

6-27, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	6-30-30
UNDERTAKER Daniel Kehan	ADDRESS 716 E 25th

Spec.—1-30—M. & T.—250 Blks

E 58413 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58413

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St. 17-26 Ward)

2-FULL NAME Annie Mattie Daniels

(a) RESIDENCE NO. 724 Pierce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

6 If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 6 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Daniels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Daniels (Address) 724 Pierce St

Filed 3-0-1930, 19 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1930, to June 26, 1930, that I last saw h— alive on June 28, 1930, and that death occurred, on the date stated above, at 11 20 a.m.

The CAUSE OF DEATH* was as follows:

Sickle Cell Anemia

(duration) about 2 mos ds.

CONTRIBUTORY (Secondary) Diarrhea (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Carrie M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

20 UNDERTAKER Daniel Caton

DATE OF BURIAL 6-30 1930

ADDRESS 916 Eutaw

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58414

CERTIFICATE OF DEATH.

101 901

E 58414

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 837 Vine St. 18-76 WARD)

2-FULL NAME Mrs. John Saunders

(a) RESIDENCE NO. 837 Vine ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Ruby May Saunders

6 DATE OF BIRTH (month, day, and year) March 10, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) Orderly

(c) Name of employer Univ. Md.

9 BIRTHPLACE (city or town) (State or country) Abbeville S. C.

PARENTS

10 NAME OF FATHER Willie Saunders

11 BIRTHPLACE OF FATHER (city or town) Abville (State or country) S. C.

12 MAIDEN NAME OF MOTHER Nellie Black

13 BIRTHPLACE OF MOTHER (city or town) Abbeville (State or country) S C

14 Informant Ruby May Saunders (Address) 837 Vine Street.

15 Filed JUN 30 1930 H. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27/1930

17 I HEREBY CERTIFY, That I attended deceased from 5/27/1930. to 6/27/1930. that I last saw him alive on 6/27/1930, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

Pulmonary Edema

(duration) .... yrs. .... mos 2½ ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) .... yrs. 1 mos. .... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical & History

(Signed) W. Bosley Bishop M. D.

, 19 (Address) 709 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery

DATE OF BURIAL 6/30 1930

UNDERTAKER Walter B. Spriggs

ADDRESS 849 W. Hamburg St.

Spec.—1-30—M. & T.—250 Bks

E 58415

E 58415 HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Archer ST. 21-29 WARD)

2-FULL NAME Charles Hoffman

(a) RESIDENCE NO. 503 Archer ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Hoffman

6 DATE OF BIRTH (month, day, and year) Nov. 15, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker 48

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary E. Damman

(Address) 503 Archer St.

15 Filed JUN 30 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28/30.

17 I HEREBY CERTIFY, That I attended deceased from May 21, 19 30 to June 28, 19 30

that I last saw h.. alive on June 28, 19 30

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Terminal

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cirrhosis Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harwood Kelly M. D.

6/28, 1930 (Address) 9027 Walsh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

DATE OF BURIAL June 30, 1930

20 UNDERTAKER Mrs. Mrs. J. W. Zimfel & Son

ADDRESS 801 N. Fayette

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58416

CERTIFICATE OF DEATH.

44 E 58416

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3400 Chesley Ave. WARD) 15-65

2-FULL NAME Helene Hofmann

(a) RESIDENCE NO. 3400 Chesley Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Geo. Hofmann

6 DATE OF BIRTH (month, day, and year) Dec. 11-1869

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	6	17	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER Victor Delaprez

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant Geo. Hofmann Jr. (Address) 3400 Chesley Ave

15 Filed ... 19 ... C. HAMILTON JONES, M. D. Registrar

1 30 1930 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28/1930

17 I HEREBY CERTIFY, That I attended deceased from about Jan ..., 1929, to June 28, 1930, that I last saw h[er] alive on June 28, 1930, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Hepatic Carcinoma

(duration) several yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac hypertrophy

(duration) several yrs. mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NT Date of ...

Was there an autopsy? NT

What test confirmed diagnosis? —

(Signed) A. W. Wright, M. D.

6/30, 1930 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL July 19 30

20 UNDERTAKER Geo M. Zink (Son)

ADDRESS 811 N. Wolfe

Spec.—1-30—M. & T.—250 Bks.

58417. HEALTH DEPARTMENT—CITY OF BALTIMORE X 37 E 58417.

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 4-30 WARD)

2-FULL NAME James Huntley

(a) RESIDENCE NO. Sandsdowne, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1910

7 AGE: Years 20 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 CERTIFIED BY CHAS. SON JONES, M.D. Register

JUN 30 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1930, to June 24, 1930, that I last saw him alive on June 24, 1930, and that death occurred, on the date stated above, at 5-40 P m.

The CAUSE OF DEATH* was as follows:

Meningitis Tuberculous

(duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of June 25, 1930

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) George H. Yeager, M. D.

6-30, 1930 Address University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sandsdowne Cat. Cem. | DATE OF BURIAL June 30, 1930

20 UNDERTAKER Euston Sons | ADDRESS Ellicott City

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58418

E 58418

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1100 N Appleton Ward 16-22

2-FULL NAME Lillie E Cooley

(a) RESIDENCE No. Uniontown Carroll Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced. (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alfred B Cooley

6 DATE OF BIRTH (month, day, and year): Sept 6 1862

7 AGE: Years 67 ~~68~~ | Months 9 | Days 21 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Dress Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Carrollton Co
(State or country) Md

PARENTS

10 NAME OF FATHER G W H Harbaugh

11 BIRTHPLACE OF FATHER (city or town) Carrollton Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Susan M Gore

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant H H Harbaugh
(Address) Westminster Md

15 Filed JUN 30 1930 C. HAMPSON JONES, M. D. Registrar
BY R Hall

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion
Sudden
(duration) ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Error of Diet
(duration) ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? 1100 N. Appleton

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) ..... M. D.
June 27 1930 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: June 30 1930

20 UNDERTAKER: W M Routson

ADDRESS: 2238 N ~~Arch~~ Smith

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58419

CERTIFICATE OF DEATH.

187-006

E 58419

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 22-33 Ward)

2-FULL NAME G. Frederick Huntley

(a) RESIDENCE NO. 20 E. Henrietta St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Huntley

6 DATE OF BIRTH (month, day, and year) June 28, 1888

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	42	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Pipe-fitter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Canada

PARENTS

10 NAME OF FATHER David Huntley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Canada

12 MAIDEN NAME OF MOTHER Sarah Ligget

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa.

14 Informant Mrs. Mabel Huntley

(Address) 20 E. Henrietta St.

15 Filed ....., 19 C. HAMILTON JONES, M. D. Registrar

30 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to deep laceration of Perineum. Accidental Death. Injured by Crane.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Clifford Zollet, M. D. (Coroner)

6/28 1930 (Address) 2739 Eastern Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Western Electric Co. Point Breeze.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md Date of Burial June 30 1930

UNDERTAKER John F Denny ADDRESS 715 L. 9th St

very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 58420

CERTIFICATE OF DEATH

90 ✓

E 58420
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 122 E. Cross St. St.) 24-33 Ward)

2-FULL NAME Marie Sohl.

(a) RESIDENCE NO. 122 E. Cross St. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Married.

5a If married, widowed or divorced (or) WIFE of Michael Sohl.

6 DATE OF BIRTH (month, day, and year) November 6, 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57	7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None. 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Michael Sohl. (husband)
(Address) 122 E. Cross St.

15 Filed ..... 1930 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

6/30 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL July 1 1930

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

Spec.—3-10-21—M&T—1500 Blks.

58421

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58421

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH Maryland General Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. S. 12-51 WARD)

2-FULL NAME Mrs. Eliza C. Cook

(a) RESIDENCE NO. 2820 Huntingdon Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Cook

6 DATE OF BIRTH (month, day, and year) Sept 8, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	72	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fairfax Co. Va.

PARENTS

10 NAME OF FATHER John Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fairfax Co., Va

12 MAIDEN NAME OF MOTHER Mary Ann Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fairfax Co., Va

14 Informant Hospital Records

(Address)

15 Filed 3 0 1930, 19 C. HAMPSON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1930

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1930, to June 29, 1930, that I last saw her alive on June 29, 1930, and that death occurred, on the date stated above, at 5:05 P m.

The CAUSE OF DEATH* was as follows:

Gastric carcinoma

of unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema of gall bladder; toxemia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 6/26/30

Was there an autopsy? No What test confirmed diagnosis? Operative findings

(Signed) [redacted] M. D.

(Address) [redacted]

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral DATE OF BURIAL July 1, 1930

20 UNDERTAKER Horace F. Burgee ADDRESS 363 Fallsway

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58422 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58422

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 433 E. 23rd St. (Ward) 9-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benj. J. Green

(a) RESIDENCE NO. 433 E. 23rd St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Green

6 DATE OF BIRTH (month, day, and year) Oct 4, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	95	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sarah County Va.

PARENTS

10 NAME OF FATHER Harriel Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Anna Johnson

(Address) 433 E. 23rd St.

15 Filed JUN 30 1930, 19

16 Registered JUN 30 1930, 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to June 26, 1930,

that I last saw him alive on June 26, 1930,

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis & Heart Complication with old age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) old age & Debility

(duration) 1 yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. H. Hall, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL June 30, 1930

20 UNDERTAKER Mrs. H. A. Elliott

ADDRESS 1745 Eastern Ave

30 1930 C H SANG ASSISTANT

Spec.—1-30—M. & T.—250 Bks.

E 58423 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58423

CERTIFICATE OF DEATH.

91-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2344 Annapolis Road ST., 25-32 WARD)

2-FULL NAME Theo Leon

(a) RESIDENCE NO. 2344 Annapolis Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 6 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Maria L. Leon

6 DATE OF BIRTH (month, day, and year) Jan 14, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	5 ~~6~~	16 ~~15~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired Glass Worker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Retired

9 BIRTHPLACE (city or town) ..... (State or country) Pa

PARENTS

10 NAME OF FATHER Moritz Leon

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah Gutstuts

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Pa

14 Informant David Engel (Address) 2344 Annapolis Rd

15 [illegible] 30 1930.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30/30

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to June 30, 1930.

that I last saw h[illegible] alive on June 29, 1930

and that death occurred, on the date stated above, at 6.50 p. m.

The CAUSE OF DEATH* was as follows:

Uremia & Pulmonary Edema

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Senile Cerebro Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kahn, M. D.

6/30 1930 (Address) 2027 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL July 2nd 1930

20 UNDERTAKER Leach Sisters ADDRESS 1600 Madison Ave

[illegible] M. D.

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58424
1-PLACE OF DEATH

CERTIFICATE OF DEATH.
Baltimore City Hospitals

CITY OF BALTIMORE: (No. 5-8 ST., WARD)

REGISTERED NO. E 58424
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Detrich

(a) RESIDENCE NO. 302 N. Exeter ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Charles

6 DATE OF BIRTH (month, day, and year): June 18, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40		10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS
10 NAME OF FATHER: John Robinson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.
12 MAIDEN NAME OF MOTHER: Mary Halpin
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records of
(Address): Balto. City Hospitals

15 Filed JUN 30 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-25-30

17 I HEREBY CERTIFY, That I attended deceased from 6-17-30, 19..., to 6-25-30, 19..., that I last saw her alive on 6-25-30, 19..., and that death occurred, on the date stated above, at 7:10 p. m.

The CAUSE OF DEATH* was as follows:

Empyema of pleura

UNKNOWN. (duration) ...yrs. ...mos ...ds.

CONTRIBUTORY (Secondary) Nephritis, acute (duration) ...yrs. 2 mos. ...da.

18 Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical, Lab.
(Signed) Paul Padget M. D.
6-27-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart
DATE OF BURIAL: 6/30 1930
20 UNDERTAKER: Fred J. Fahey & Sons
ADDRESS: 1318 Light

Spec.—1-30—M. & T.—250 Bks.

E 7093
E 58425

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 E 58425

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 19-28 ST., WARD)

2-FULL NAME Norma Smith

(a) RESIDENCE No. 1830 Eagle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 24 - 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Malachi Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jessie Rozus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 30 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27-30

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to June 27, 1930,
that I last saw her alive on June 26, 1930,
just before midnight June 27, and that death occurred, on the date stated above, at 5 30 p. m.

The CAUSE OF DEATH* was as follows:

Rheumatic heart disease,
51 days
Myocardial failure,
(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Chorea
(duration) yrs. mos. [illegible] 51 ds

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis?

(Signed) J W Bickford, M. D.
6/27 1930 (Address) [illegible] WM

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL June 30, 1930

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 1/2 Schroeder St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

V-006
187

B 58426

CERTIFICATE OF DEATH

E 58426

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., 11-24 Ward)

2-FULL NAME Richard Woods.(C).

(a) RESIDENCE NO. 1119 Bolton St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, HUSBAND of Helen Woods.(C)

6 DATE OF BIRTH (month, day, and year) March 13, 1906.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	24	3	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Richard Woods.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Margaret Over.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Helen Woods.(C) wife.
(Address) 1119 Bolton St.

15 Filed ... 19... C. HAMPTON JONES, M. D. Registrar
JUL 1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Laceration of the Liver and Internal Hemorrhage. Occidentally struck in the abdomen by a boom.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted Texas Oil Co. Floortun. If not at place of death? June 26, 1930

Did an operation precede death? Yes. Date of June 26, 1930

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto W. Reinhardt, M. D.

6/30, 1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kennesaw Va

DATE OF BURIAL July 1 1930

20 UNDERTAKER D. John H. Owens

ADDRESS 5382 Belair

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58427

CERTIFICATE OF DEATH

28 E 58427

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1828 West Saratoga ST. 20-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie C. Buddy

(a) RESIDENCE NO. 1828 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Basil D. Buddy

6 DATE OF BIRTH (month, day, and year) June 5th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Samuel Shorb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Catherine Parr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Langdon M. Sanborn

(Address) 2767 W. North Ave.

15 Filed JUL 1930 19 HARRISON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 29th. 1930

17 I HEREBY CERTIFY, That I attended deceased from May 24. 1930. to June 29. 1930.

that I last saw her alive on June 28. 1930

and that death occurred, on the date stated above, at 5.15 A.M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. 1 mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mac Neill M. D.

6/29 19 30 (Address) 108 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	July 1st 1930
20 UNDERTAKER Joseph H. Cook	ADDRESS 1003 N. Balto St

1-30—M. & T.—100 B—50L

E 58428

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58428

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hospital (St.) 17-25 (WARD)

2-FULL NAME Mary V. Baker.

(a) RESIDENCE NO. S Parke St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	-		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm Baker
11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)
12 MAIDEN NAME OF MOTHER Veronica Price
13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Roger Price
(Address) S Parke Md

15 Filed 30 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accident. from Burns clothes caught fire while burning Grass in back yard at Home (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Chas H Brooke, M. D. Coroner
June 30, 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery, Catonsville — DATE OF BURIAL July 2 1930

20 UNDERTAKER W.C. Brooks Jr. — ADDRESS S Parke Md

Spec.—1-30—M. & T.—250 Blks

E 58429 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58429

CERTIFICATE OF DEATH.

101-00

4-25

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Johnson

(a) RESIDENCE NO. 622 W. Raborg St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Mar. 15, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	3	//	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Va.

PARENTS

10 NAME OF FATHER Columbus ?

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Seward

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-26-30

17 I HEREBY CERTIFY, That I attended deceased from 6-22-30, 19..., to 6-26-30 19...,

that I last saw h... alive on 6-26-30, 19...,

and that death occurred, on the date stated above, at 8:50 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia, lobar

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Paul Padget, M. D.

6 27 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER C. HAMPSON JONES, M.D.

ADDRESS Commissioner Health

JUN 30 1930

JUN 30 1930

Spec.—1-10-21—M&T—1500 Bks.

Rosalie Washkiewicz ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58430

CERTIFICATE OF DEATH.

44 E 58430

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 S. Bond ST. 2-4 WARD)

2-FULL NAME Rosalie Washkiewicz

(a) RESIDENCE NO. 827 S. Bond ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 28 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER Michel Jasionowski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Frank Washkiewicz
(Address) 827 S. Bond St.

Filed JUN 30 1930, 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1930

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1930, to June 30, 1930, that I last saw h[illegible] alive on June 30, 1930, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Womiting

(Signed) [illegible], M. D.

30 6 1930 (Address) 1511 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary | DATE OF BURIAL July 2 1930

20 UNDERTAKER J. O Zagrodzki | ADDRESS 1980 Eastern Ave

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 5110 E 58431

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58431

REGISTERED NO. 100

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL ST. 27-43 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No.)

2-FULL NAME Eleanore Eder

(a) RESIDENCE NO. 2911 Fleetwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mc Corrie Eder

6 DATE OF BIRTH (month, day, and year) Sept-24-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitress

(b) General nature of industry, business, or establishment in which employed (or employer) Joh Hopkins 070

(c) Name of employer Hosp

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John a Eder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hertenline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

6-30-1930. 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-30-1930

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1930, to June 30, 1930, that I last saw her alive on June 30, 1930, and that death occurred, on the date stated above, at 515 A.m.

The CAUSE OF DEATH* was as follows:

1. Arteriosclerosis
2. Myocardial Failure
3. Bronchopneumonia

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) James Bordley M. D.

6-30, 1930 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 7/3 1930

UNDERTAKER Theodore Cook

ADDRESS 1217 Sx Carr

Spec.—1-30—M. & T.—250 Bks.

E 58432 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58432

CERTIFICATE OF DEATH.

REGISTERED NO. 24-600

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2210 Lynbrook Ave. ST. 15-62 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Mallonee,

(a) RESIDENCE NO. 2210 Lynbrook Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Ephrim Mallonee,

6 DATE OF BIRTH (month, day, and year) May 12, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md

PARENTS

10 NAME OF FATHER Geo. W. Ambrose,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co. Md.

12 MAIDEN NAME OF MOTHER Mary A. Miller,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co. Md.

14 Informant Mrs Geo W Suttle

(Address) 2963 Woodbourne Ave

15 Filed JUN 30 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUN 30 1930

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to June 30, 1930,

that I last saw h[illegible] alive on June 29, 1930,

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Irvin Ebaugh, M. D.

June 30 1930 (Address) 701 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Pleasant Hill Md DATE OF BURIAL JUL 2 1930

20 UNDERTAKER Geo W Suttle ADDRESS 2700 EDMONDSON AVE.

1-30—M. & T.—100 B—50L

E 58433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58433

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2837 Mayfield Ave ST. 8-45 WARD)

2-FULL NAME Anna B. Lammert

(a) RESIDENCE NO 2837 Mayfield Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	married

5a If married, widowed, or divorced (or) WIFE of Henry E Lammert

6 DATE OF BIRTH (month, day, and year) Mar 17/1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	05	3	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER xxxx Forman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER xxxx Yerkes

13 BIRTHPLACE OF MOTHER (city or State or country) Balto., Md.

14 Informant Henry E. Lammert (Address) 2837 Mayfield Ave

15 Filed JUL 1 1930, 19... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] Coroner, M. D.

6/30/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 7/1 1930

20 UNDERTAKER E. J. Fanning Sons

ADDRESS 1938 E. Lafayette av.

JUL 1 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58434

CERTIFICATE OF DEATH

24-001

E 58434

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 155 E Randall ST. 24-34 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Lockhart

(a) RESIDENCE NO. 155 E Randall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Howard B Lockhart

6 DATE OF BIRTH (month, day, and year): March 16 1854

7 AGE: Years 76 | Months 3 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Winchester Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Etta Ruth Broll

(Address) 155 E Randall

15 Filed 1-1-1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28 1930

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1930 to June 28, 1930

that I last saw her alive on June 28, 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. B. Campbell M. D.

6/30 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 1 1930

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 58435

CERTIFICATE OF DEATH

E 58435

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1388 W. Northern St., 13-59 (Ward)

2-FULL NAME Braxton R. Tolbert

(a) RESIDENCE NO. 1388 W. Northern St., 13 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
About 58.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant (Address)

Filed 19 C. HAMPSON JONES, M. D. Registrar

L 1-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Dilatation of Heart General Arterio Sclerosis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

6-26 1930 (Address) 767 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cem. DATE OF BURIAL June 1930

20 UNDERTAKER M. E. Tasson ADDRESS 8411 W 37th

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58436 90 E 58436

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 619 S. Wolfe ST. 2-4 (WARD)

2-FULL NAME Henry Baners

(a) RESIDENCE NO. 619 S. Wolfe ST., ... WARD .....
(Usual place of abode) (If ooo-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or wife)~~ Margaret Baners

6 DATE OF BIRTH (month, day, and year) Feb 22 69

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Water Dept.

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Ed. Baners

11 BIRTHPLACE OF FATHER (City or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Augusta Ey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

14 Informant Margaret Baners
(Address) 619 S. Wolfe St

15 Filed JUN 1 1930 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29/30

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to June 29, 1930, that I last saw h~~i~~e alive on June 29, 1930, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Heart Disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Myocardial Insuff.

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Emil Zeigler, M. D.

6/30, 1930 (Address) 1000 E. Baltor.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Matthews — DATE OF BURIAL 7/2 1930

20 UNDERTAKER Philip Herring — ADDRESS 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

(Transcript) E 58437

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58437

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

I—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 8-16 WARD)

2—FULL NAME Victor Meyers

(a) RESIDENCE NO. 1624 Llewelyn Ave ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24 1925

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Victor Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. D.

12 MAIDEN NAME OF MOTHER Barbara Haber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Victor Meyers

(Address) 1624 Llewelyn Ave

15 Filed ..... 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1930, to June 29, 1930, that I last saw him alive on June 29, 1930 and that death occurred, on the date stated above, at 2 15 p m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Rhinitis - Pharyngitis Double Otitis Media)

(duration) ..... yrs. ..... mos. 26 ds.

CONTRIBUTORY (Secondary) Streptococcus Meningitis

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Mastoid Date of June 21, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lumbar puncture

(Signed) Myron G Tull, M. D.

6/30, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 6 1930
UNDERTAKER Corley & Co. Inc.	ADDRESS 1021 W Fayette

Spec.—1-30—M. & T.—250 Blks

E 58438

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58438

CERTIFICATE OF DEATH.

33

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (St.) B (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Smith

(a) RESIDENCE NO. 26 S. Duncan ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. D

PARENTS

10 NAME OF FATHER William Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. D

12 MAIDEN NAME OF MOTHER Sarah Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D.C.

14 Informant Sarah Wheatley

(Address) 3. S. Castle St

15 Filed ....., 19 C. HAMPSON JONES, M. Registrar

1935

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30-30

17 I HEREBY CERTIFY, That I attended deceased from 5/27/30, 19....., to 6/30, 1930, that I last saw h[illegible]ive on 6/30, 1930 and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Abdominal Colitis

Acute Phlebitis

Pleurisy

(duration) ....yrs. 2 mos ....ds.

CONTRIBUTORY (Secondary) .....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

6/30 1930 (Address) 6 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery

DATE OF BURIAL July 3 1930

ADDRESS 1631 orleans st

20 UNDERTAKER D Edward Bryan

Spec.—1-10-21—M&T—1500 Bks.

E 58439 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 58439

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 S Bond ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Hazel

(a) RESIDENCE NO. 120 S Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md

PARENTS

10 NAME OF FATHER John Shorts

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Annie Henderson

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Lucinda Fields
(Address) 230 S Bethel st

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1930

17

I HEREBY CERTIFY, That I attended deceased from June 14, 1930, to June 28, 1930,

that I last saw h[illegible] alive on June 27, 1930,

and that death occurred, on the date stated above, at 3 Pa m.

The CAUSE OF DEATH* was as follows:

Pulm. Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R T Young, M. D.

6/30/30 (Address) 1429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bay View Cemetery

DATE OF BURIAL July 2 1930

20 UNDERTAKER E Bryan

ADDRESS 631 Orleans

TION is very important. See instructions on back of certificates.

1-30—M. & T.—250 Blks.

E 58440

E 58440 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 24 North Hospital

CITY OF BALTIMORE: (No.) 6 Caroline ST., (or) WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Cavalier

(a) RESIDENCE NO. 1315 E Lafayette St.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Wm. Cavalier.

6 DATE OF BIRTH (month, day, and year) 8/19/1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	10	11	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Elmer Field

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Sussie Field Embrey

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Wm. Cavalier

(Address) 1315 E. Lafayette Av.

15 Filed 1-1930, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30-30.

17 I HEREBY CERTIFY, That I attended deceased from 6-26-30, 19, to 6-30-30, 19, that I last saw h alive on 6-30-30, 19, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 6/26/30

Was there an autopsy? No

What test confirmed diagnosis? Obstetrician

(Signed) W. T. Lendrix, M. D.

19 (Address) 1316 Hoyt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL 7/3/30, 19

20 UNDERTAKER Mary T. Pretty

ADDRESS 1735 Harford Av

Spec.—1-31—M. & T.—250 Bks

E 58441 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 58441

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ____ ST. 5-8 WARD)

REGISTERED NO. ____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Scott

(a) RESIDENCE NO. 505 N. Central Ave. ST., ____ WARD ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Scott

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Rose Scott

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed 6-1 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-27-30

17 I HEREBY CERTIFY, That I attended deceased from 6-14-28, 19..., to 6-27-30, 19..., that I last saw h e alive on 6-27-30, 19..., and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic + acute.

More than 2 yrs. mos ds.
(duration)

CONTRIBUTORY (Secondary) Arteriosclerosis and Hypertension (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Paul Padgett, M. D.

6-28-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury

DATE OF BURIAL July 1 1930

UNDERTAKER John W Henderson

ADDRESS 1507 E Monument

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58442

CERTIFICATE OF DEATH

161-001

E 58442

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General ST., Hospital)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Hallwig

(a) RESIDENCE NO. 622 Mt Holly St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 6-26-30

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
0	✓	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Victor P. Hallwig

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Saunders

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant Hospital record
(Address)

15 Filed 1-1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-29-30

17 I HEREBY CERTIFY, That I attended deceased from 6-26-30, 19..., to 6-29-30, 19...,
that I last saw h.... alive on 6-29-30, 19...
and that death occurred, on the date stated above, at 11:15 P.m. ST

The CAUSE OF DEATH* was as follows:

Prematurity.
Mother Treated with
eclampsia. Hypertension
albuminuria. Coma (duration) ...yrs...mos...ds.

CONTRIBUTORY
(Secondary)
(duration) ...yrs...mos...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

6/30/30 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	7/1/30

20 UNDERTAKER Engel & Sterling Sulthorp Fayette ADDRESS

1-30—M. & T.—100 B—50L

E 58443

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 58443

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 432 N. Luzerne ST. 6-10 WARD)

2-FULL NAME Eliza Jane Geiman

(a) RESIDENCE NO 432 N. Luzerne ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Abraham H. Geiman

6 DATE OF BIRTH (month, day, and year) June 12/1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	0	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co., Md.
(State or country)

PARENTS

10 NAME OF FATHER Razenus Fowble

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Elizabeth Fittinger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Wm. F. Geiman
(Address) 432 N. Luzerne Ave

15 Filed 1930 C. HAWSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Bree, M. D.
Coroner

6/30/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Valley, Md DATE OF BURIAL July 2 1930

20 UNDERTAKER Frank Brockbon Son ADDRESS 1906 E. Lond

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 58444

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44

E 58444

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 S. Belnord ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Sustar

(a) RESIDENCE NO. 801 S. Belnord ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Sustar

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Jos. Hudecek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mary Sustar (Address) 801 S. Belnord Ave

15 Filed 1-1930 (As HARRISON JONES, M. Registrar) per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29/30

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to June 29, 1930, that I last saw her alive on June 29, 1930 and that death occurred, on the date stated above, at 5.02 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Xray

(Signed) H. J. Davidson, M. D.

. 19 (Address) 3035 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 2 1930

20 UNDERTAKER By Francis Brandon ADDRESS 426 Gilmor St

Spec.—1-30—M. & T.—250 Blks

E 58445

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58445

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS ST. 76-27 (D)

CITY OF BALTIMORE: (NO.

2-FULL NAME Julia Ford

(a) RESIDENCE NO. None. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1852 (?)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78 (?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 9D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard County (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown.

14 Informant Records of BALTIMORE CITY HOSPITALS

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29, 1930.

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1927, to June 29, 1930, that I last saw her alive on June 29, 1930, and that death occurred, on the date stated above, at 1:00 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute.

Morethon 3 yrs. mos. da.
(duration)

CONTRIBUTORY (Secondary) Arteriosclerosis. unknown.
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Paul Padget, M. D.

6-29-1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery

DATE OF BURIAL July 2 1930

20 UNDERTAKER D. Edward Bryan

ADDRESS 1631 orleans st

Mary E. Pongee

E 58446 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 46 E 58446

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 804 George Street-Rear (WARD)

CITY OF BALTIMORE: (NO. ..... ST. .....

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Pongee

(a) RESIDENCE NO. 804 George ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Irene Pongee

(Address) 804 George St

15 Filed 1 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-28-30

17 I HEREBY CERTIFY, That I attended deceased from 5-3, 19 30, to 6-28, 19 30

that I last saw her alive on 6-27, 19 30

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

General Metastases

(duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. B. Bailey, M. D.

, 19 (Address) 425 N. Carlin Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Star Cemetery

DATE OF BURIAL July 1 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Richmond St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 58447

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58447

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: NO. Station Hospital, Holabird Q.M. Depot. (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Vogel

(a) RESIDENCE. NO. Holabird Q.M. Depot ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred xx yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? xx yrs. xx mos. x ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Not married

6 DATE OF BIRTH (month, day, and year) February 1901

7 AGE 29 Years 4 Months xx Days If LESS than 1 day, x hrs. or min.

8 OCCUPATION OF DECEASED Soldier.

(a) Trade, profession or particular kind of work Army serial No.6073715.

(b) General nature of industry, business, or establishment in which employed (or employer) U.S.Army

(c) Name of employer Government.

9 BIRTHPLACE (city or town) Philadelphia, (State or country) Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Official Army Records.
(Address) Holabird Q.M. Depot, Balto.Md.

15 Filed JUL 1 - 1930 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1927, to June 27, 1930, that I last saw him alive on June 27, 1930, and that death occurred, on the date stated above, at 11:20 P.m.

The CAUSE OF DEATH* was as follows:
Hemorrhage, internal and shock.

Accidental.

(duration) 7½ hours. xx yrs. xx mos. xx ds.

CONTRIBUTORY (Secondary) Fracture, transverse, complete, 3rd, 4th, 5th, 6th and 7th Ribs, right.
(duration) x yrs. x mos. x ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? no Date of xx

Was there an autopsy? No

What test confirmed diagnosis? XRay and physical findings.

(Signed) C.H.Witherell, Major, M.C. M. D.

6/30/30 (Address) Holabird Q.M. Depot.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL July 1 1930

20 UNDERTAKER H. L. Levinson - Bro

ADDRESS 1127 Balto St

INFORMATION IS very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 58448 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58448

CERTIFICATE OF DEATH.

REGISTERED NO. 15-5X

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3842 (St.) Resterstown Rd (Ward) 15-5X

2-FULL NAME Wm. K. Shelley -

(a) RESIDENCE NO. 3842 (St.) Resterstown Rd (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9+ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Lillie Matthews Shelley

6 DATE OF BIRTH (month, day, and year) June 1st 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 066

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer City

9 BIRTHPLACE (city or town) City (State or country)

PARENTS

10 NAME OF FATHER Samuel Shelley

11 BIRTHPLACE OF FATHER (city or town) City (State or country)

12 MAIDEN NAME OF MOTHER Fannie Kinnear

13 BIRTHPLACE OF MOTHER (city or town) City (State or country)

14 Informant Lillie M Shelley (Address) 3842 Resterstown Rd

15 Filed 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 - 1930

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1925, to June 30, 1930

that I last saw him alive on June 30, 1930,

and that death occurred, on the date stated above, at 2. P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Embolus

Sudden (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Nathaniel Earle, M. D.

, 19 (Address) 210 Govans Falls Pkwy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL July 2 1930

20 UNDERTAKER W. C. Pickney & Son ADDRESS North Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

71-601

E 58449 REGISTERED NO.

E 58449

1—PLACE OF DEATH

CITY OF BALTIMORE: (a) Sydenham Hospital ST. 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur Neilson

(a) RESIDENCE NO. 1806 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	8 10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Keene (State or country) N. H.

PARENTS

10 NAME OF FATHER Frank Neilson

11 BIRTHPLACE OF FATHER (city or town) N. H. (State or country)

12 MAIDEN NAME OF MOTHER Eliz Rourke

13 BIRTHPLACE OF MOTHER (city or town) N. H. (State or country)

14 Informant Arthur Neilson

(Address) 1806 Frederick Ave

15 Filed ... 19 ... C. HAMILTON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1930, to June 18, 1930, that I last saw him alive on June 18, 1930 and that death occurred, on the date stated above, at 2 15 a. m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Neck

Probably Streptococcic

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron S. Teele, M. D.

6/23, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR REMOVAL

DATE OF BURIAL 19

ADDRESS

UNDERTAKER

UNIVERSITY OF MARYLAND

Baltimore Health.

JUL 1 - 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58450

CERTIFICATE OF DEATH

90 E 58450

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 W Lombard ST. 18-29 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia E Holland

(a) RESIDENCE NO. 1213 W Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married.

3a If married, widowed, or divorced, HUSBAND of (or) WIFE of J Timothy Holland

6 DATE OF BIRTH (month, day, and year) May 10th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) / 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Daniel Tierney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr William Holland

(Address) 1213 W Lombard St.

15 Filed JUL 1 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30th 1930.

17 I HEREBY CERTIFY, That I attended deceased from 6/18/, 1930, to 6/30/, 1930, that I last saw h[illegible] alive on 6/30/, 1930 and that death occurred, on the date stated above, at 3 30 P.M. D.S.

The CAUSE OF DEATH* was as follows:

Hypertension hypernephroma

Arteriosclerosis - Cystitis

(duration) unknown yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) C. Bernard F. Tierney, M. D.

6/30/1930 (Address) 410 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 7/3/1930

20 UNDERTAKER John J Cowan Son.

ADDRESS 901 Hollins St.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58451

90 E 58451

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 W. Lanford ST., 18-29 WARD)

2—FULL NAME Mrs. Esther O'Connor.

(a) RESIDENCE NO. 1023 W Lanford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

6a If married, widowed, or divorced HUSBAND ~~of~~ (or) WIFE of Peter J. O'Connor

6 DATE OF BIRTH (month, day, and year) April 4th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	70	1 2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house work.

(b) General nature of industry, business, or establishment in which employed (or employer): /

(c) Name of employer: 037

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Mary Clifford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mr. Peter J. O'Connor.

(Address) 1023 W Lanford St

15 Filed ..., 19... Registrar

C. HAMILTON JONES, M.D.

L [illegible]-1930 R P C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28th 1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929 to June 28, 1930, that I last saw h[illegible] alive on June 25, 1930 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Annular Fibrillation

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis

(Signed) Augustine P. Van Schaick M.D.

(Address) 4818 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state. (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 7/2/1930

20 UNDERTAKER: John J. Cowan & Son.

ADDRESS: 901 Hollins St.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58452

CERTIFICATE OF DEATH.

123 E 58452

REGISTERED NO.

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver St. 24-33 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christie Parsons

(a) RESIDENCE No. 1253 Battery Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug - 17 - 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales lady 067

(b) General nature of industry, business, or establishment in which employed (or employer) in Dept Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Alfred Parsons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Samantha Wilkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Parsons (Address) 1253 Battery ave

15 Filed JUL 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30-30

17 I HEREBY CERTIFY, That I attended deceased from 6-24, 1930, to 6-30, 1930

that I last saw he alive on 6-30, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Obstructive Jaundice

Gall Stones

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Uraemia & Toxaemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

(Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL 7/3 1930

20 UNDERTAKER D. J. Fen Mc Cully

ADDRESS 130 E Fort.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58453

E 58453

CERTIFICATE OF DEATH.

REGISTERED NO. 31 Un Heuman E 58453

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3444 Leverton Ave ST., 26-37 WARD)

2-FULL NAME Virginia Riehl.

(a) RESIDENCE NO. 3444 Leverton Ave ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Riehl.

6 DATE OF BIRTH (month, day, and year) Sept. 2nd 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Horney.

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant John Riehl. (Husband) (Address) 3444 Leverton Ave

Filed JUL 1 - 1930 H. C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28th 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/1/30, 19..., to 6/28/30, 19..., that I last saw her alive on 6/28/30, 19..., and that death occurred, on the date stated above, at 5 05 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 2 yrs. mos da.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Heuman M. D.

6/29/30 (Address) 1710 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL July 1st 1930

20 UNDERTAKER Lilly - Zeiler Co.

ADDRESS 400 S. Wolfe St.

Spec.—1-30—M. & T.—950 Blu

E 58454

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58454

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ST. 7-4 WARD)

2-FULL NAME Patrick J Walsh.

(a) RESIDENCE NO. 428 S. Washington ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah B. Walsh.

6 DATE OF BIRTH (month, day, and year) Jan 17th 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bldg Inspector for B&O

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael Walsh

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Hannah Devine

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Hospital Records
(Address)

15 Filed JUL 1 - 1930 H. [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30-30

17 I HEREBY CERTIFY, That I attended deceased from 6-13, 1930, to 6-30, 1930, that I last saw him alive on 6-30, 1930 and that death occurred, on the date stated above, at 11 15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis.

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis CVR

(duration)* ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/15/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical + operative.

(Signed) J Leyko, M. D.

6/30, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery. DATE OF BURIAL July 3rd 1930

UNDERTAKER Lilly & Geiler Bros. ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58455 31 E 58455

CERTIFICATE OF DEATH.

REGISTERED NO. 2743

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6011 Glendale Ave ST. Hamilton Ave)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Floretta Eliason Stockett.

(a) RESIDENCE NO. 6011 Glendale Ave ST. Hamilton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of James Edgar Stockett

6 DATE OF BIRTH (month, day, and year) Sept 9th 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
28	28	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Eliason

11 BIRTHPLACE OF FATHER (city or town) Balto. Md (State or country)

12 MAIDEN NAME OF MOTHER Margaret Berry

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant James Edgar Stockett (Address) 6011 Glendale Ave

15 Filed JUL 1 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29th 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 3rd, 1929, to June 29th, 1930, that I last saw h[illegible] alive on June 29th, 1930, and that death occurred, on the date stated above, at 6 10 a. m.

The CAUSE OF DEATH was as follows:

Pulmonary Miliary Tuberculosis

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman F. Greene, M. D.

June 30, 1930 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL July 2nd, 30

20 UNDERTAKER Lilly & Zeiler Bros. — ADDRESS 4033 W. North Ave

FILL IN very important. See instructions on reverse side.

1-30—M. & T.—100 B—50L

E 58456 ✓ E 58456

38

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 6-11 WARD)

2-FULL NAME Charles J. Ettlinger

(a) RESIDENCE NO 110 N. Hare ST., 6 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene M. Ettlinger

6 DATE OF BIRTH (month, day, and year) June 11/1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	0	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk 509
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Penna. R.R.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Sebastian Ettlinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Irene M. Ettlinger
(Address) 116 N. Hare St

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Cardiac Disease-Tertiary Syphillis
(duration) 15 yrs. mos ds.
CONTRIBUTORY (Secondary) Intravenous injection of Salvarsan- about (duration) 1/2 hrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) [illegible] M. D. Coroner

6/1/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 2 1930
20 UNDERTAKER Lilly & Zeiler	ADDRESS 4030 W. North

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 58457

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. E 58457

1-PLACE OF DEATH South Balto. Gen. Hosp. ST. 2435 (NUMBER) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (NO.) ST., WARD

2-FULL NAME Mrs Emma Jackson

(a) RESIDENCE NO. 1456 Andre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Robert L. Jackson

6 DATE OF BIRTH (month, day, and year) May 25 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Md

PARENTS

10 NAME OF FATHER James E Newell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cumberland Md

12 MAIDEN NAME OF MOTHER Bertha Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Md

14 Informant Robert Jackson (Address) 1456 Andre St

C. HARRISON JONES, M. D.

15 Filed ....., 19 .... By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30-30

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to June 30, 1930, that I last saw her alive on June 30, 1930, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinomatous Uterus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pelvic Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of 6-25-30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Frances P. Gilbert, M. D.

, 19 (Address) 1413 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland Mount Cem. Md

DATE OF BURIAL July 3 1930

20 UNDERTAKER Charles L. Stevens

ADDRESS 158 E Fort Ave

TION IS very important. See instructions on

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58458

CERTIFICATE OF DEATH.

91-002

E 58458

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 803 E 41st ST., 9-47 WARD)

2-FULL NAME Jane A Foos

(a) RESIDENCE NO. 803 E. 41st — ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas E. Foos

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE: Years 78; Months —; Days 6; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Clabey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Loretta S. Foss

(Address) 803 E 41st St.

15 Filed JUL 1 - 1930

C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1930, to June 29, 1930.

that I last saw h[illegible] alive on June 29, 1930

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Arteria - Sclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis Allen, M. D.

, 19 (Address) 616 Dumbarton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 7/2/1930

UNDERTAKER: J. J. Moran

ADDRESS 3000 E. Baltimore

TION is very important See instructions on back of certificate

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58459

CERTIFICATE OF DEATH

129 E 58459

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 E 41st ST., 9-47 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Hamilton

(a) RESIDENCE NO. 621 E 41st ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

5 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Richard Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Caroline Vernon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Mary E Kerr

(Address) 621 E 41st

15 Filed 1 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29-30

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1930, to June 29, 1930, that I last saw h[illegible] alive on June 29, 1930 and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Chr. Nephritis, Chr. Myocarditis,

(duration) 5-T yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) E. W. Bishop, M. D.

(Address) 501 Sheridan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 7/2/1930

20 UNDERTAKER J. A. Moran

ADDRESS 3090 E Baltimore

Cor.—10-10-29—A Co.—100 Bks.

E 58460

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 58460

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balt City Hospital St. 16-26 Ward)

2-FULL NAME Jane Parker

(a) RESIDENCE NO. 1042 Edmonson Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Parker

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) North Carolina

PARENTS

10 NAME OF FATHER Louis Mitchell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Susie Dean

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant George B. Mitchell
(Address) 1042 Edmonson Ave.

15 ..... 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1932

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Nephritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted If not at place of death? 1042 Edmonson

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

June 30 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Alwoodie N. C.	July 1, 1930
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1727 Aisquith

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

1 - 1930

Spec.—2-29-28—L. P. S.—500 Bks.

E 58461

HEALTH DEPARTMENT—CITY OF BALTIMORE

88

E 58461

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 E 25th ST., 9-46 WARD)

2—FULL NAME Mary F Pelletier

(a) RESIDENCE NO. 601 E 25th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Pelletier

6 DATE OF BIRTH (month, day, and year): 9-14-1881

7 AGE: Years 48 49 | Months 8 | Days 16 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Boston Mass

PARENTS

10 NAME OF FATHER: John Deming

11 BIRTHPLACE OF FATHER (city or town) (State or country): Boston Mass

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Boston Mass

14 Informant: Frank Pelletier

(Address): 601 E 25th St

15 Filed JUL 1 1930, 19 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1930

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to July 1, 1930.

That I last saw her alive on June 30, 1930

and that death occurred, on the date stated above, at M. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): acute myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edw. L. Zimmerman M. D.

7/1, 1930 (Address) 2858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Boston Mass.

DATE OF BURIAL: 7/2 1930

20 UNDERTAKER: Mary M. Medford

ADDRESS: 501 E 21st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58462

CERTIFICATE OF DEATH

E 58462

1—PLACE OF DEATH
CITY OF BALTIMORE: (No.) Bon Secours Hospital (ST.) (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George T. Corrigan

(a) RESIDENCE NO. 132 W. Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) ---

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): Loyola College
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Henry Corrigan
11 BIRTHPLACE OF FATHER (city or town) Harford Co.
(State or country) Maryland
12 MAIDEN NAME OF MOTHER Mary W. Burch
13 BIRTHPLACE OF MOTHER (city or town) Charles Co
(State or country) Maryland

14 Informant Miss Fannie Corrigan
(Address) 132 West Lanvale Street

15 Filed 7-1-1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/30/30

17 I HEREBY CERTIFY, That I attended deceased from 11/12, 1929, to 6/30, 1930, that I last saw h. alive on 6/28, 1930 and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of lumbar vertebrae

(duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs...mos...ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 1/6/30

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Thos. E. Stacy, Jr., M. D.

.19 (Address) Bon Secours Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Ignatius-Hickory, Md.	7/2 19 30

20 UNDERTAKER Henry U. Mears and Son ADDRESS 805 N. Calvert

Important. See instructions on back of this sheet.

Cor.—10-10-29—A Co.—100 lbs.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58463

CERTIFICATE OF DEATH

90 E 58463

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1809 St Paul St., 12-19 Ward)

2-FULL NAME Ella B. Wheeler

(a) RESIDENCE NO. 1809 St Paul St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/18/1853

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
76	9	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): do
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Chas. Wheeler

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Zell

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Kate Wheeler
(Address) 1809 St Paul

15 Filed ..... 19.. Registrar C. HAMPSON JONES, M. D.

Reg. No.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. dis. heart

Instantly (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. T. Kemp, Coron, M. D.

July 1 1930 (Address) 1639 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 7/2 1930

20 UNDERTAKER: Wm. Coale — ADDRESS: 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58464

CERTIFICATE OF DEATH

89

E 58464

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2114 Mt. Royal Terrace ST. 13-54 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Chapman Lowndes

(a) RESIDENCE NO. 2114 Mt. Royal Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth C. Lowndes

6 DATE OF BIRTH (month, day, and year) June-14-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew J. Lowndes

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Va

12 MAIDEN NAME OF MOTHER Mary ... Bucknall

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co. (State or country) Md.

14 Informant Mrs. Wm C. Lowndes, Jr.

(Address) Manhattan Beach A. B. P. O. Md.

15 Filed ... 1930, 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-30-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1923, to June 30, 1930, that I last saw him alive on June 25, 1930 and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac hypertrophy with beginning decompensation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Physical Exam

(Signed) Jno A Lichtscher M. D.

July 1, 1930 (Address) 12 E. Eager St., Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery, DATE OF BURIAL July 2/30

20 UNDERTAKER Stewart & Mowen Company ADDRESS 108 W. North Ave.

1-1930

Spec.—1-30—M. & T.—250 Blks

(Fusco) ✓

E 58465 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 58465

CERTIFICATE OF DEATH. X 49

1-PLACE OF DEATH Mercy Hospital.

REGISTERED NO._____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. _____ ST. #7 WARD)

2-FULL NAME Katherine Fusco

(a) RESIDENCE No. 119 Goffe St., ST., New Haven, Conn. WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stenographer 009
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Conn

PARENTS
10 NAME OF FATHER Gaetano Fusco
11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy
12 MAIDEN NAME OF MOTHER Philomina Bove
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hospital Records
(Address)

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1930.

17 I HEREBY CERTIFY, That I attended deceased from 6-12, 1930, to 7-1, 1930, that I last saw h[illegible] alive on 7-1, 1930, and that death occurred, on the date stated above, at 1.30 m.

The CAUSE OF DEATH* was as follows:

Brain Tumor
(Endothelioma) (?)
(duration) 2 (?) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 7-1-30
Was there an autopsy? No
What test confirmed diagnosis Clinical & Operative

(Signed) J Leyko, M. D.
7/1, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Haven Conn — DATE OF BURIAL 7/1 1930

20 UNDERTAKER Geo E Shirley Fueton & Tafuto — ADDRESS

TION is very important. See instruction on back of certificate

Spec.—1-30—M. & T.—250 Blks

E 58466 HEALTH DEPARTMENT—CITY OF BALTIMORE D 58466

CERTIFICATE OF DEATH.

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital St. 14-20 (Ward)

2-FULL NAME William Westcott

(a) RESIDENCE No. 1402 Argyle Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Rose Westcott

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. Hospital

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Record (Address)

15 Filed 1-1930 C. HAMPSON JONES, M.D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-1-30

17 I HEREBY CERTIFY, That I attended deceased from June 26, 19 30, to July 1, 19 30, that I last saw him alive on July 1, 19 30, and that death occurred, on the date stated above, at 12 30 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Hemorrhagic Nephritis

(duration) days mos 15 da.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy (duration) unknown mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedarhill Md. DATE OF BURIAL July 5 1930

20 UNDERTAKER Fred A. Patterson ADDRESS Glenville Md.

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58467 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 129 E 58467

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST., 10-1st (WARD)

2-FULL NAME Thomas Clifford

(a) RESIDENCE NO. 722 Myrna St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~: Mary M. Clifford

6 DATE OF BIRTH (month, day, and year): March 12-1884

7 AGE: Years 46. Months 3 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: City Scavenger
(b) General nature of industry, business, or establishment in which employed (or employer): ...
(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm H. Clifford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Mary Joynes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mary M Clifford
(Address): 722 Myrna St

15 Filed JUL 2 1930 By ..... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1-1930

17 I HEREBY CERTIFY, That I attended deceased from 6-30-30, 19..., to 7-1, 19 30., that I last saw him alive on 7-1-30, 19..., and that death occurred, on the date stated above, at 12, 30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) ..., yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary) Anemia (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laboratory —

(Signed) Wm H. Lueddeke M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: July 5 1930

UNDERTAKER: Robt J. Turner Jr — ADDRESS: 1442 N Broadway

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Jos Rosai

HEALTH DEPARTMENT—CITY OF BALTIMORE

58468

CERTIFICATE OF DEATH

199 E 58468

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Mercy Hosp. St. H-7 (Ward)

2-FULL NAME Rosai

(a) RESIDENCE NO. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Austria
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Stimpson Laceal 829 Cumb Lancaster St
(Address)

15 Filed JUL 2 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30. 30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Valvular Endocarditis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY
(Secondary)

(duration) ...yrs. ...mos. Hazel ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? yes Date of

Was there an autopsy? yes

What test confirmed diagnosis? —

(Signed) A. J. Riley, M. D.

July 2 1930 (Address) 629 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cemetery	July 2 — 1930
20 UNDERTAKER	ADDRESS
George A Weber	705 S Amity St

IMPORTANT: This certificate should be carefully examined before it is signed. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58469 ✓ E 58469

CERTIFICATE OF DEATH

REGISTERED NO. E 58469

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hospt. St., 79 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leander Whitting.

(a) RESIDENCE NO. (913 J St Sparrows Pt. St., Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	C.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5th 1905

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	25	1	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER John F. Whitting

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Bridie Richards

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant (Address) John F. Whitting 913 J St Sparrows Pt. Md

Filed JUL 2 - 1930 HERMAN JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1/30 '92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Odema Lungs (Autopsy at
Pleural Effusion Hopkins)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [signature], M. D.

7/2/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glenwood Pk. Va — DATE OF BURIAL July 3 1930

UNDERTAKER Mrs. R.G. Elliott — ADDRESS 1725 Oakland Av

Use ink in entering. Spaces must not be left blank. Words may be abbreviated, but it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58470

CERTIFICATE OF DEATH.

113 ✓ E 58470

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 927 Harford Ave St. 10-14 Ward)

2-FULL NAME Susie A.Hurt.

(a) RESIDENCE NO. 927 Harford Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 28th. 1929

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Hurt.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Emily Taylor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Emily Hurt Mother

(Address) 927 Harford ave.

15 Filed_____ 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions-(Probably Gastro-intestinal-Dentition)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Collins M. D.
(Coroner)

7/2/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemt. Date of Burial July 21 1930

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 172 Ashland Ave

R. Curtis M. D.

Do not write in this space. Information applied for must be properly classified. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 2 - 1930 C. HAROLD WILLIS

Spec.—1-30—M. & T.—250 Blks.

E 58471

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58471

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2308 E. Madison St. WARD) 9th

2-FULL NAME John Howard Loper

(a) RESIDENCE NO. 2308 E. Madison St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70 71	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Glass Worker

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER John Loper

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey.

12 MAIDEN NAME OF MOTHER Mary Cantrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant Mrs Maude Sluss

(Address) 2308 E. Madison St

15 Filed 2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 - 1930

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to July 1, 1930,

that I last saw h/ alive on July 1, 1930, and that death occurred, on the date stated above, at 12-15 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation

Myocarditis

Diabetes

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Rheumatic arthritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas Francis M. D.

, 19 (Address) 470 Hospital Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Rest Cem. Millville N.J.

DATE OF BURIAL July 3 1930

ADDRESS Woodbury

20 UNDERTAKER Isaac Sykes

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

238500
Lab 58472

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58472

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 79 WARD)

2-FULL NAME Violet Causion

(a) RESIDENCE NO. Parks Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 1 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Causion

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address)

15 Filed 2 1930 C. HAMILTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1930

17 I HEREBY CERTIFY, That I attended deceased from 6-30, 1930, to 7-1-, 1930, 11:30 a.m. that I last saw h.r alive on 7-1-, 1930, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus ? Ic

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Tonsillitis chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes - Tonsillectomy & Adenoidectomy Date of July 1, 1930

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. R. Clark Grove, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stevenson Cem.	July 1930
UNDERTAKER	ADDRESS
H. C. Brooks	Parks Md

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58473

CERTIFICATE OF DEATH

E 58473

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1040 Edmondson Ave., 16th Ward)

2-FULL NAME Garfield Woods

(a) RESIDENCE NO. 1040 Edmondson Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Celestine Woods

6 DATE OF BIRTH (month, day and year): April 1890

7 AGE: Years 40 | Months 2 | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Labore
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Texas
(State or country)

PARENTS

10 NAME OF FATHER: Woods

11 BIRTHPLACE OF FATHER (city or town): Texas
(State or country)

12 MAIDEN NAME OF MOTHER: Rachel Smith

13 BIRTHPLACE OF MOTHER (city or town): Texas
(State or country)

14 Informant: Celestine Woods
(Address): 1040 Edmondson

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): July 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Regular M. D.

19 (Address) 1040 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Auburn

DATE OF BURIAL: July 31 1930

20 UNDERTAKER: Monroe & Mayhew

ADDRESS: Cornelius

AUG 2 - 1930

(Should be carefully supplied. Age should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec.—1-30—M. & T.—250 Bks

E 58474 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58474

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ..... S. 16-22 WARD)

REGISTERED NO. E 58474

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Coates

(a) RESIDENCE NO. 1012 Hillock Alley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Richard Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Records of Balto. City Hospitals

15 Filed ..... 19 ..... Registrar

JUL 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30-30

17 I HEREBY CERTIFY, That I attended deceased from 6-9-30, 19 ..... to 6-30-30, 19 ....., that I last saw her alive on 6-30-30, 19 ....., and that death occurred, on the date stated above, at 1:20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) UNKNOWN yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) UNKNOWN yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Examn.

(Signed) Paul Padget, M. D.

7-1, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL July 3rd 1930

UNDERTAKER Frank Ellis & Hamilton

ADDRESS 700 N. Carey

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58475 ✓ 161-001 E 58475

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST. 14-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Peters

(a) RESIDENCE NO. 60 Mellar ave - Catonsville WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 30 - 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ 0-0

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore
(State or country) maryland.

PARENTS

10 NAME OF FATHER August Hm. Peters

11 BIRTHPLACE OF FATHER (city or town) Catonsville
(State or country) maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Bass

13 BIRTHPLACE OF MOTHER (city or town) Paducah
(State or country) Kentucky

14 Informant August Hm. Peters
(Address) 60 Mellar ave. Catonsville

15 Filed JUL 2 1930 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 1, 1930 that I last saw her alive on July 1, 1930 and that death occurred, on the date stated above, at 9:40 P. M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) ✓ yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no ✓

What test confirmed diagnosis? Clinical

(Signed) Randolph J. Schork M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salem Lutheran Cem.

DATE OF BURIAL July 2, 1930

20 UNDERTAKER Easton Sons

ADDRESS Ellicott City

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

58476 90 E 58476

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 W. Franklin ST. 18-26 WARD)

2-FULL NAME Robert Blagmond

(a) RESIDENCE NO. 1006 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan-18-1919

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	11	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Blagmond

11 BIRTHPLACE OF FATHER (city or town) W. Maryland & Co
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Sallie Chase

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co
(State or country) Maryland

14 Informant William Blagmond
(Address) 1006 W. Franklin

15 Filed 2-1930 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/30/30

17 I HEREBY CERTIFY, That I attended deceased from 1/10, 1929, to 6/30, 1930.

that I last saw him alive on 6/29, 1930.

and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? No.

What test confirmed diagnosis? none.

(Signed) Dan'l Franklin, M. D.

7/1, 1930 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lion Cemetery

DATE OF BURIAL July 3, 1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 58477

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58477

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3434 (Street) Mondawmin Ave (WARD) 15-61

2-FULL NAME William Henry Bordley

(a) RESIDENCE NO. 3434 Mondawmin Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Orem Bordley

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman of Carriers

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Post Office

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fairlee Md.

PARENTS

10 NAME OF FATHER Samuel C Bordley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fairlee Md.

12 MAIDEN NAME OF MOTHER Mary A. Nicholson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs Kate Orem Bordley

(Address) 3434 Mondawmin Ave

Filed JUL 2 - 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1930

17 I HEREBY CERTIFY That I attended deceased from July 1, 1930, to July 1, 1930, that I last saw him alive on July 1, 1930, and that death occurred, on the date stated above, at 4.30 P m. DS

The CAUSE OF DEATH* was as follows:

Cancer of Stomach, General and Liver

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis and Arteriosclerosis (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hesselius Cole, M. D.

(Address) 2202 Hanson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	July 3, 30
UNDERTAKER	ADDRESS
Wm Hickner Sons	Mottu Pa

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 58478

CERTIFICATE OF DEATH.

E 58478

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1220 Edyth ST. 5-8 (WARD)

2-FULL NAME Sarah Berry

(a) RESIDENCE NO. 1220 Edyth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of James E. Berry

6 DATE OF BIRTH (month, day, and year) June 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant (Address) James Berry Sr 1220 Edyth St

15 Filed JUL 2 - 1930 19 C. HAMPTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/29/1930

17 I HEREBY CERTIFY, That I attended deceased from Various times for the last 2 years, 19....,

that I last saw h.. alive on June 28, 1930,

and that death occurred, on the date stated above, at 1:P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Hypertension 3 Cerebral Hemorrhage

(duration) 3 yrs. mos da.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) W. W. Gorman, M. D.

7-2-1930 (Address) 117 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashburton DATE OF BURIAL July 3 1930

UNDERTAKER D. Mus P. A. Ellicott ADDRESS 1220 Ashburton

TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58479

CERTIFICATE OF DEATH

16-001

E 58479

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST. 913 WARD)

2-FULL NAME Anna Keefe

(a) RESIDENCE NO 921 N.Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John C. Keefe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant John C. Keefe

(Address) 921 N.Castle St

Filed 2 - 1930 C. HAMILTON JONES, M. D. Registrar

By RPC

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. [illegible] Coroner, M. D.

7/1/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL July 2 1930

20 UNDERTAKER Geo. M. Fink & Son

ADDRESS 811 N. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—60L

E 58480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

166 ✓ E 58480

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST., 7-12 WARD)

2-FULL NAME Marie Lease

(a) RESIDENCE NO 701 N. Patterson Park Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Lease

6 DATE OF BIRTH (month, day, and year) Dec 1/1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	6	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Auld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hopkins Records

(Address)

15 Filed JUL 2 1930, 192 C. HAMILTON JONES, M. D. Registrar

By RMH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 30/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury Poisoning

Suicide

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Ho-kins

What test confirmed diagnosis?

(Signed) J. H. Calvert, M. D. Coroner

July 1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross. Home Co

DATE OF BURIAL July 4 1930

20 UNDERTAKER Geo M. Smith Sons

ADDRESS 811 N W St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

148 E 58481

CERTIFICATE OF DEATH.

E 58481

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No.) 12-60 ST. (Ward)

2-FULL NAME Ida Johnson

(a) RESIDENCE NO. 443 E 23rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mitchell Johnson

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE Years 38 Months ... Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm E Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Thomas

(Address) 443 E 23rd St

15 ... Registrar

JUL 2 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30-30

17 I HEREBY CERTIFY, That I attended deceased from 6-29- 1930 to 6-30 1930

that I last saw her alive on 6-30 1930

and that death occurred, on the date stated above, at 12 M. a. m.

The CAUSE OF DEATH* was as follows:

a Nephritis

Hypertension (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pregnancy (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. S. Butler, M. D.

7/1, 1930 (Address) 425 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 7/3 1930

20 UNDERTAKER Samuel Kennedy

ADDRESS 1178 N Bridge

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

238/57 E 58482

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58482

CERTIFICATE OF DEATH.

3 V

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 15-21 WARD)

2-FULL NAME Earl Morris

(a) RESIDENCE No. 15-26 N. Stricker ST. ST— WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Child

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 26-1925

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER Earl Morris

11 BIRTHPLACE OF FATHER (city or town) Va —
(State or country)

12 MAIDEN NAME OF MOTHER Mary Shangen

13 BIRTHPLACE OF MOTHER (city or town) Va —
(State or country)

14 Informant Records — (Address) Johns Hopkins Hospital

15 Filed JUL 2 1930 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30-30

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1930, to June 30, 1930, that I last saw him alive on June 30, 1930, and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonary
Tuberculoma, Left cerebrum
Tuberculoma Cerebellum

(duration) yrs. 2 mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tuberculin

(Signed) R. C. H. Wesson — M. D.

7/1, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mundy Court Va	July 2, 1930
UNDERTAKER Emmit F. Hensley	ADDRESS 378 Gilmore

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—1-12-23—M&T—500 Bks.

85483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 58483

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers Hosp. St. 1251 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert C. Wittman

(a) RESIDENCE NO. 2114 Maryland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~cont~~ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Do Not Know

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Do Not Know

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant John J. Fahey Jr.
(Address) 1318 Light St

15 Filed [illegible] 1930 C. HAMILTON JONES, M. Registrar
By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1929 to July 2, 1930.

that I last saw h[illegible]ive on July 2, 1930

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Femoral Thrombosis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? stethoscope

(Signed) A. J. Conley, M. D.

7-2-1930 (Address) Vol. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 7/4 1930

20 UNDERTAKER J. J. Fahey & Son — ADDRESS 1318 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE OR CONDITION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58484 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58484

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hosp ST. 5-68 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Freda La Mar

(a) RESIDENCE NO. 826 Whitmar av ST., WARD

(Usual place of abode) *(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Charles Lamar

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Henry Velte

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Clara Burk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles La Mar (Address) 18 Whitmore

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

JUL 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/2/30

17 I HEREBY CERTIFY, That I attended deceased from 7/1, 1930, to 7/2, 1930, that I last saw her alive on 7/2, 1930, and that death occurred, on the date stated above, at 6:20 P. M. E. ST.

The CAUSE OF DEATH* was as follows:

Gangrenous appendicitis, ruptured

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Generalized peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 7/1/30

Was there an autopsy? yes

What test confirmed diagnosis? Clin & operation

(Signed) Henry J. Mettrick, M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL July 4th 19 30

20 UNDERTAKER J J Bailey & Son

ADDRESS 1318 Light

CAUSE OF DEATH TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58485

CERTIFICATE OF DEATH.

129 ✓ E 58485

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 268 University Pkwy St., 12-49 Ward)

2-FULL NAME Mary Elizabeth Stayer

(a) RESIDENCE NO. 268 University Pkwy St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anderson Stayer.

6 DATE OF BIRTH (month, day, and year) 9/27/1862

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER James Stanton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) London.

12 MAIDEN NAME OF MOTHER Eliz Appel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Wm Stayer

(Address) 268 University Pkwy

15 Filed_____ C. HAMPSON JONES, M. D. Registrar

By _____

JUL 2 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1st 30 19

17 I HEREBY CERTIFY, That I attended deceased from June 1 - 1929 to July 1st 1930, that I last saw her alive on July 1st 30, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Herrman, M. D.

7/1/30 (Address) 913 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — Date of Burial 7/3 1930

20 UNDERTAKER J. J. Zahey & Sons — ADDRESS 1318 Light St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58486 ✓ E 58486

CERTIFICATE OF DEATH

E 58486

1—PLACE OF DEATH Maryland General Hosp. REGISTERED NO. 90

CITY OF BALTIMORE: (No. 1750 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Julia Gladding

(a) RESIDENCE NO. 216 E. 22nd St. ST., WARD Baltimore Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Married

5a If married, widowed, or divorced (or) WIFE of Samuel Gladding

6 DATE OF BIRTH (month, day, and year) May 1, 1868

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
62	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) County. Md.

PARENTS

10 NAME OF FATHER John Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co.

12 MAIDEN NAME OF MOTHER Mary Klossman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co.

14 Informant Hospital records. (Address)

15 Filed JUL 2 1930 19 HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/2/30

17

I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 2, 1930 that I last saw h[illegible] alive on July 1, 1930 and that death occurred, on the date stated above, at 8:10 A m. (ST.)

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Arteriosclerosis

unknown (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

1-8 (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? Blood pressure

(Signed) Robert F. Chenoweth, M. D.

, 19 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL 7/5 1930

20 UNDERTAKER Mclean Cook — ADDRESS 217 St. Paul

(1) Fill in all questions as far as possible. Important. See instructions on back of certificates.

Cor.—10-10-28—A Co.—100 Bks.

E 58487

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

199 E 58487

1-PLACE OF DEATH

City of Baltimore: (No. St. Jos. Hosp. St., 37-42 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Julia Edwards

(a) RESIDENCE NO. 3004 Southern Avenue St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Robert M. Edwards

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	62	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) St. Mary's County
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. C. Tennyson

11 BIRTHPLACE OF FATHER (city or town) St. Mary's
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophia Leach

13 BIRTHPLACE OF MOTHER (city or town) St. Mary's
(State or country) Maryland

14 Informant Mrs. Ferdinand Engelhardt
(Address) 3004 Southern Avenue

15 Filed 7-2-1930 O. HAMPSON JONES, M. D. Registrar
by ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
While crossing street at intersection was knocked down by a Sun Taxi, operated by unauthorized driver
Hour ... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Fract Skull
... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Fremont & North

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) ... M. D.

7/1, 1930 (Address) 2939 E. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 7/3 1930

20 UNDERTAKER Henry U. Mears & Son — ADDRESS 505 N. Calvert

Spec.—1-10-21—M&T—1500 Bks.

E 59408 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 59408

CERTIFICATE OF DEATH. + 139

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (NO. Howard Kelly Hospital STREET WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Bauman

(a) RESIDENCE NO. 1658 Wakefield Ave ST. Youngstown Ohio. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced (or) WIFE of Mr I. R Bauman

6 DATE OF BIRTH (month, day, and year) Oct 21st 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	42	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) St Louis
(State or country) Michigan.

PARENTS

10 NAME OF FATHER Frank R. Shank

11 BIRTHPLACE OF FATHER (city or town) Medina
(State or country) Ohio.

12 MAIDEN NAME OF MOTHER Ella Rasor

13 BIRTHPLACE OF MOTHER (city or town) Wadsworth
(State or country) Ohio

14 Informant Mrs I. R. Bauman
(Address) Youngstown Ohio.

15 Filed C. HANSON JONES, M. D. Registrar

L 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from June 30. 1930. to July 2nd 1930.
that I last saw h[illegible] alive on July 2nd 1930
and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:—

Post operative Shock

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Degenerated Fibroid of uterus (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of July 2nd 1930

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hulbert Keith, M. D.

7-2-1930 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Youngstown Ohio	July 2 1930
20 UNDERTAKER	ADDRESS
Chas. G. Black	142 W. Forth Ave

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58489 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58489

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital St. H-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Plant~~ Daniel Shipley Jr

(a) RESIDENCE NO. 411 Main St. ST. Centerstown Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 26-1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Daniel Shipley Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Tilly A. Lowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Daniel Shipley Sr

(Address) Centerstown Md

Filed JUL 2 - 1930 C. HAMPSON JONES, Registrar

By CCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 2, 1930,

that I last saw him alive on July 2, 1930,

and that death occurred, on the date stated above, at 10:05 A m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis ~~septicemia~~

(duration) yrs. mos 10 da.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of July 1, 1930

Was there an autopsy? Not Seen Change

What test confirmed diagnosis?

(Signed) George H. Yeager, M. D.

7/2, 1930 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Md DATE OF BURIAL July 5 1930

UNDERTAKER E. L. Upton ADDRESS Stamfordsted Md

CAUSE OF DEATH in plain (crude, so that it may be properly coded) TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58490

CERTIFICATE OF DEATH

185 E 58490

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) W. Balto Gen Hos (Ward) 16-67

2-FULL NAME Albert R. Hancock

(a) RESIDENCE NO. 3001 Harlem Ave., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. S. Hancock

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1844

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	86	6 x5	29.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R. Employ.
(c) Name of employer (Deceased)

9 BIRTHPLACE (city or town) Annapolis
(State or country) Md.

PARENTS

10 NAME OF FATHER John F. Hancock

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Leeke

13 BIRTHPLACE OF MOTHER (city or town) Annapolis
(State or country) Md.

14 Informant Mary Hancock
(Address) 3001 Harlem Ave

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH was as follows: Accident fell down steps
Concussion of brain
Fractured base
(duration) yrs. days

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death 3001 Harlem Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. C. Funk, M. D.
June 30th 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Valley Mem

20 UNDERTAKER Joseph L. Cook

DATE OF BURIAL July 3" 1930

ADDRESS 1003 W. Balto St

JUL 2 - 1930

No. 18. Where disease is contracted elsewhere than at place of death, this fact should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—1. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5849T

CERTIFICATE OF DEATH

90 E 5849T

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2405 Foster Ave ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Wasielewska

(a) RESIDENCE NO. 2405 Foster Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Daughter

(Address) 2405 Foster Ave

15 C. HAMPSON JONES, M. D.

Filed June 2 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1930

17 I HEREBY CERTIFY, That I attended deceased from April, 1930, to June 30, 1930, that I last saw her alive on June 29, 1930 and that death occurred, on the date stated above, at 6 30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema 2 days
Cardiac decompensation Bronchopneumonia
Auricular Fibrillation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam & Laboratory

(Signed) A. F. Ellis, M. D.

July 1, 1930 (Address) 24 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Md.

DATE OF BURIAL July 3 1930

20 UNDERTAKER John F. Wolfe & Son

ADDRESS

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificates.

L 2 1930

Spec.—1-30—M. & T.—250 Blks

E 58492 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58492

91-00

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3030 Dillon St. 1-1 WARD)

2-FULL NAME Henry T. Jackson

(a) RESIDENCE No. 3030 Dillon ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Annina Jackson

6 DATE OF BIRTH (month, day, and year): 1845

7 AGE: Years 85; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Henry Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Sommers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Annina Jackson 3030 Dillon St.

15 2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from January 15, 1930, to July 1st, 1930, that I last saw him alive on July 1st, 1930, and that death occurred, on the date stated above, at 8-30 P. m.

The CAUSE OF DEATH* was as follows:

General Arterio Sclerosis

(duration) yrs. 5 mos 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Isaac N. Hilles, M. D.

July 2nd 1930 (Address) 10 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Jul 3 1930

20 UNDERTAKER: J. A. Moran ADDRESS 3909 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last illness of ... TION is very important. See instructions on back of certificates.

2

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58493

CERTIFICATE OF DEATH

129

E 58493

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 N Broadway ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Scheide

(a) RESIDENCE NO. 1507 N Broadway ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. — mos. — ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Scheide

6 DATE OF BIRTH (month, day, and year) August 9-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Pessel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Kappes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Scheide

(Address) 1507 N Broadway

15 Filed JUL 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-2-30.

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to July 2, 1930, that I last saw her alive on July 1, 1930 and that death occurred, on the date stated above, at 7 08 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia 4 days

Broncho Pneumonia 2 days

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) ... yrs. ... mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uraemia

(Signed) Thos. D. Stevens, M. D.

7-2, 1930 (Address) 2875 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL 7/5/30

20 UNDERTAKER Mary T. Pugh

ADDRESS 1735 Harford Ave

DEATH in plain terms, so that it may be properly classified. Last statement must be important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 58494

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58494

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1643 Chelsea ST. 8-17 WARD)

2-FULL NAME Rebecca Wollering

(a) RESIDENCE NO. 1604 E. Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John B. Wollering

6 DATE OF BIRTH (month, day, and year) 11/2 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Alex Irwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliz Brune

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) John D. Wollering 1604 E. Lafayette Ave

15 Filed 2-1930 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1st-1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930 to July 1, 1930

that I last saw h.er alive on July 1st, 1930

and that death occurred, on the date stated above, at 11 15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1604 E. Lafayette Ave.

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray.

(Signed) Thos. F. Stevens, M. D.

7-2, 1930 (Address) 2818 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 7/4/30

20 UNDERTAKER Mary T. Puth — ADDRESS 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXAMINATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58495 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58495

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hosp. ST., 9th WARD)

REGISTERED NO. 86-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Kearney

(a) RESIDENCE NO. 1701 Ensor St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) November 2 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	16 8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Luke J. Kearney

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sadie Agnes Brogan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mr. Luke J. Kearney (Father) (Address) 1701 Ensor Street

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1930, to July 2, 1930, that I last saw h[illegible] alive on July 2nd, 1930, and that death occurred, on the date stated above, at 1 35 A m.

The CAUSE OF DEATH* was as follows:

Meningitis

Convulsions

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Bilateral otitis media

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 30, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A B Kindrick, M. D.

, 19 (Address) 1 E Dreyer Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL July 4 1930

20 UNDERTAKER Stewart Women Co ADDRESS 108 W North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CONDITION is very important. See instructions on back of certificates.

JUL 2 - 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 58496

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

78

E 58496

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 S. Bouldin St. 9b-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Seitz Jr.

(a) RESIDENCE NO. 513 S. Bouldin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Seitz Sr.

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Betty Emick

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Charles Seitz Sr (Father)
(Address) 513 S. Bouldin St

15 Filed 2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1930, to July 1st, 1930, that I last saw him alive on June 30th, 1930, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) 10 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.

19 (Address) 4700 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL 1st Evangelical Cemetery

DATE OF BURIAL July 4 1930

20 UNDERTAKER Henry Sander & Sons Inc.

ADDRESS Baltimore St & Broadway

OF DEATH in plain terms, so that it may be properly classified. Label statement of occupation important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58497

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58497

CERTIFICATE OF DEATH.

91-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 Maryland Ave. ST., 12-20 WARD)

2-FULL NAME Margaret Lewis Taliaferro Manspile

(a) RESIDENCE NO. 2004 Maryland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chapman Manspile

6 DATE OF BIRTH (month, day, and year) Nov 10 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Virginia

PARENTS

10 NAME OF FATHER Gen Alex G Taliaferro

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Agnes H Marshall

13 BIRTHPLACE OF MOTHER (City or town) .....
(State or country) Virginia

14 Informant Miss Margaret Manspile
(Address) 2004 Maryland Ave

15 Filed 2-1930 C. HAMPTON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1 1930 to July 1st 1930,
that I last saw he alive on July 1st 1930,
and that death occurred, on the date stated above, at 10 55 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Artio-Sclerosis

(duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Senile Pulmonary Edema

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Robert E. Cuthbert M. D.

7/7, 1930 (Address) 711 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlottesville Va	July 3 1930
20 UNDERTAKER	ADDRESS
John O Mitchell & Sons	910 Eutaw Place

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT NUMBER OF DAYS
TION is very important. See instructions on back of certificate.

L 2

Spec.—1-30—M. & T.—250 Blks

E 58498

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58498

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Provident Hosp ST. 14-20 WARD)

2-FULL NAME James Kyler

(a) RESIDENCE No. 71 Clay St. Annapolis Md WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10	1	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS
10 NAME OF FATHER Ed. Kyler
11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md
12 MAIDEN NAME OF MOTHER Hannah Evans
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Ed. Kyler
(Address) Annapolis Md

JUL 2 - 1930 C. HARRISON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2/30

17 I HEREBY CERTIFY, That I attended deceased from July 2, 19 30, to July 2, 19 30.
that I last saw h. alive on July 2
and that death occurred, on the date stated above, at 4.50 p. m.

The CAUSE OF DEATH* was as follows:
Ruptured appendix
Peritonitis
(duration) ..... yrs. ..... mos 3 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) B Lewis, M. D.
7/2, 19 30 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md
DATE OF BURIAL July 2 1930
UNDERTAKER B L Hopkins
ADDRESS Annapolis Md

Fill in DEATH in plain terms, so that it may be properly classified. Exact statement of cause very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58499

CERTIFICATE OF DEATH

199 E 58499

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto City Hosp ST., 11-24 (WARD)

2-FULL NAME Helen Flick

(a) RESIDENCE NO 1214 N. Charles St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Dont Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
21	Dont	know		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cabaret Dancer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dont know

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Dr. H. J. Frame

(Address) 2939 W. Eldorado St

15 Filed ..... 192 ..... C. HAMPSON JONES, M. D. Registrar

12 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto in which she was riding (left front seat) collided with milk wagon overturning

(a) ..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fract Skull C.C. Fract Mandible

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Eastern & 37th St

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Coroner & PM

(Signed) H. J. Frame, M. D.

11-3, 1930 (Address) 2939 W. Eldorado Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Yonkers N.Y.

DATE OF BURIAL July 2 1930

20 UNDERTAKER Geo M. Smith & Son

ADDRESS 811 N. Howard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Spec.—1-12 21—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58500 E 58500

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 4510 Bayonne Ave WARD) 90

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Stein

(a) RESIDENCE No. 4510 Bayonne Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Matthias Stein

6 DATE OF BIRTH (month, day, and year): Oct 10-1850

7 AGE: Years 79 Months 8 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Geo Koener

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Mary Amels

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Jos M. Lenz
(Address): 4510 Bayonne Ave

15 Filed 19 Registrar C. HAMPSON JONES, M. D.

1. 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1929, to July 1, 1930, that I last saw h alive on July 1, 1930, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis (Chronic)

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Pessano M. D.

7. 2. 1930 (Address) 514 Druid Park Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem DATE OF BURIAL: July 4 1930

20 UNDERTAKER: Geo M. Enid & Son ADDRESS: 811 N. Wolfe

IMPORTANT—Should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-30—M. & T.—200 Blks

20275 E 58501

E 58501 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2032 Hoffman ST. 8-17 WARD)

2-FULL NAME George W. Charlton

(a) RESIDENCE NO. 2032 E Hoffman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Charlton

6 DATE OF BIRTH (month, day, and year) July 2, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary A. Charlton Secretary
(Address) 2032 E. Hoffman St

15 Filed JUL 3 1930, 19 ..... C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1930, to July 2, 1930, that I last saw h.. alive on July 1, 1930, and that death occurred, on the date stated above, at 3:00 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Arteriosclerosis, General
Arterial Hypertension

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Urea and Ex Laparotomy

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) Albert Abrahams M.D.

7/2, 1930 (Address) 2035 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL July 5 1930

UNDERTAKER Wm Cook — ADDRESS Gay St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 58502 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58502

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Carrollton Ave ST.) 16-23 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Camper

(a) RESIDENCE No. 1119 Carrollton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Haywood Camper

6 DATE OF BIRTH (month, day, and year) April 3 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md

PARENTS

10 NAME OF FATHER James J. Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER Amanda Dobson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co. Md.

14 Informant John Camper

(Address) 724 Carrollton Ave

15 Filed JUL 3 - 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-1-30

17 I HEREBY CERTIFY, That I attended deceased from 6-24, 1930, to 6-30, 1930, that I last saw her alive on 6-30, 1930, and that death occurred, on the date stated above, at 6, A m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 2 mos da.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. + Physical examination

(Signed) Frank A Saunders, M. D.

7-1-1930 (Address) 1029 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL July 5 1930

UNDERTAKER John W. Trader

ADDRESS 1027 Round Hill

IMPORTANT is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 58503

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58503

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1130 Mt. Pleasant St. 11-24 WARD)

2-FULL NAME Mary A. Knot

(a) RESIDENCE NO. 1130 Mt. Pleasant WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Poland	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Knot.

6 DATE OF BIRTH (month, day, and year) 1895.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Noah Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary A. Knot
(Address) 1130 Mt. Pleasant

15 Filed JUL 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1930

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1930, to July 4, 1930, that I last saw h.. alive on July 4, 1930, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Progressive Carcinoma of Stomach

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Hill, M. D.

(Address) 724 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	July 5th 1930
UNDERTAKER	ADDRESS
Charles H. Alexander	Woodbine Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-20—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58504

CERTIFICATE OF DEATH

90 E 58504

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1720 Wilmer St. 14-20 (Ward)

2-FULL NAME Herbert Carter.

(a) RESIDENCE NO. 1420 Wilmer St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day and year): 1900

7 AGE: Years 30 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Va.
(State or country)

PARENTS

10 NAME OF FATHER: Isaac Carter

11 BIRTHPLACE OF FATHER (city or town): Va.
(State or country)

12 MAIDEN NAME OF MOTHER: Aunta Gibson

13 BIRTHPLACE OF MOTHER (city or town): Va.
(State or country)

14 Informant: Wm Gibson
(Address) 1365 W Lanvale

Filed JUL 3 - 1930 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): July 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	7/3 1930
20 UNDERTAKER	ADDRESS
Thomas E. Pearson	130 Pulaski

Do not write in this space. Please answer all questions carefully and completely. Information must be supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58505

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/ E 58505

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 14-59

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Smallwood

(a) RESIDENCE NO. 2215 Etting st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER M. Sutton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 Filed JUL 3 - 1930 C. Hartman Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to July 1, 1930, that I last saw her alive on July 1, 1930, and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) [signature], M. D.

7-1 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 7/5 1930

20 UNDERTAKER T. E. Kelson

ADDRESS 3838 Freetman

IMPORTANT: See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 58506

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58506

CERTIFICATE OF DEATH

185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital St., 7-13 WARD)

2-FULL NAME Allen Hill Jr.,

(a) RESIDENCE NO 802 Shutter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5/1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	0	20 25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farm Hand
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Saml. Johnson, Hurlock, Md.

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Allen Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Annie Hill
(Address) 802 Shutter St.

15 Filed JUL 3 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis-Fractured Skull at base
Accidently fell from load of wheat
& wheel ran over head at Hurlock,
Md. on June 30/30 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) Coroner, M. D.

7/2/30 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL July 3rd 1930

20 UNDERTAKER Samuel Hemsley ADDRESS Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 58507

E 58507

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 412 N. Dallas ST. 6-9 (WARD)

2-FULL NAME Joseph W. N. Jones

(a) RESIDENCE NO. 412 N. Dallas ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) June 25 1900

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
29	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Wm. H. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Annie Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William H. Jones (Address) 1330 McCulloh St

15 Filed JUL 3 - 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1-30

17 I HEREBY CERTIFY, That I attended deceased from June 28 1930 to July 1 1930 that I last saw him alive on July 1 1930 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

1 Acute Pneumonia

Lobar

(duration) ..... yrs. ..... mos 12 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible] July 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 7-4 1930

ADDRESS .....

20 UNDERTAKER Bipon & Wright 1218 McCulloh St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 58508

E 58508 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 945 N. Patterson Pk ave ST., 7 (WARD)

2-FULL NAME Katherine M. Hole

(a) RESIDENCE NO. 945 N. Patterson Pk. ave ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (h) HUSBAND of (or) WIFE of John A. Hole.

6 DATE OF BIRTH (month, day, and year) Dec 19th 1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael Zeiler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Kalbenbacher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John A. Hole. 945 N. Patterson Pk. Ave.

15 Filed 3-1930 C. HANSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from April, 1927, to 7/1, 1930, that I last saw h[illegible] alive on 7/1, 1930, and that death occurred, on the date stated above, at 8.05 P. m.

The CAUSE OF DEATH* was as follows:

Asthenia-Arteriosclerosis with Myocarditis

(duration) Gradual yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. C. Hanson, M. D.

July 3, 1930 (Address) 1403 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 4th 1930.
20 UNDERTAKER Lilly & Zeiler Inc.	ADDRESS 403 S. Wolfe St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58509 45 E 58509

CERTIFICATE OF DEATH

1—PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Fayette & Calhoun ST. 12 WARD) 19

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Rosie James

(a) RESIDENCE NO. 325 Ringold ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~Female~~ Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Prince George Co—Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sofihia Schröder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince George

14 Informant E H B Parker

(Address) 47 Washington Ave Apt 6

15 Filed JUL 3 1930, 19 HARRISON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to July 2, 1930, that I last saw h~~er~~ alive on July 2, 1930 and that death occurred, on the date stated above, at 5:40 P m.

The CAUSE OF DEATH* was as follows:

Generalized carcinoma toes of Intestine

(duration) 19 yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Bleeding from rectum

(Signed) M. D. Schröder, M. D.

19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bonnie Hill Cemt

DATE OF BURIAL July 6 1930

20 UNDERTAKER E H B Parker

ADDRESS 47 Wash- St

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 58510

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58510

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 S. Durham ST. 24 WARD)

2-FULL NAME Emma Den Hartog

(a) RESIDENCE NO. 710 S. Durham ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Nicholas Den Hartog

6 DATE OF BIRTH (month, day, and year) Mch 12th 1890

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
40	3	18	

8 OCCUPATION OF DECEASED none.

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer none

9 BIRTHPLACE (city or town) Mobile, Alabama (State or country)

PARENTS

10 NAME OF FATHER John Heiner

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Eckert

13 BIRTHPLACE OF MOTHER (city or town) Washington D.C. (State or country)

14 Informant Nicholas Den Hartog

(Address) 710 S. Durham St.

Filed JUL 3 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1930, to June 30, 1930,

that I last saw her alive on June 30, 1930,

and that death occurred, on the date stated above, at 5 50 P. m.

The CAUSE OF DEATH* was as follows:

Uremia — chronic nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac hypertrophy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NT Date of —

Was there an autopsy? NT

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

July 1, 1930 (Address) 1014 S. Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery DATE OF BURIAL July 3rd 1930

20 UNDERTAKER Lilly & Zeller Inc. ADDRESS 408 S. Wolfe St.

Rec

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 58511

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 58511

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1031 Riverside Ave (St.) 24-33 (Ward)

2-FULL NAME Mary Hooper

(a) RESIDENCE No. 1031 Riverside Ave ST., WARD

(Usual place of abode) About

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Wm. Hooper

6 DATE OF BIRTH (month, day, and year): April 29 ?

7 AGE: About 73 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: at home

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Wm Hooper

(Address): 440 Trinidale St

Filed 7-1930, 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-1st 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930, to July 1st, 1930

that I last saw her alive on July 1st, 1930;

and that death occurred, on the date stated above, at 4 55 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. 5 mos. da.

CONTRIBUTORY (Secondary) Acute Rheumatism

(duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Shelete M. D.

7th, 1930 (Address) 1279 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross a a Co — DATE OF BURIAL: 7-4 1930

UNDERTAKER: E + B Harlr 115 E — ADDRESS: West St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 58512 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 58512

122-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST. 2-4 (WARD)

2-FULL NAME Joseph Czernikowski

(a) RESIDENCE NO. 28- S. Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Czernikowski

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore Copper Wks

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

PARENTS

10 NAME OF FATHER Michael

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Hospital Record (Address)

15 Filed 1930 C. HI[illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/2/1930

17 I HEREBY CERTIFY, That I attended deceased from 11/13 29, 19 to 7/2/30, 19, that I last saw h/is alive on 7/2/30, 19, and that death occurred, on the date stated above, at 7/2/30 a.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver - (?)

a

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cocaitis

(duration) 5 yrs. 8 mos. ds.

18 Where was disease contracted ? If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Partial Autopsy

What test confirmed diagnosis?

(Signed) Eldred Roberts, M. D.

7/2/1930 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cemetery DATE OF BURIAL July 5 1930

20 UNDERTAKER George A. Weber ADDRESS 705 S. Amm st

ATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

Tunski

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58513

CERTIFICATE OF DEATH

194 ✓ E 58513

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 625 S Wolfe st. St., 7-4 Ward)

2-FULL NAME John Tunski

(a) RESIDENCE NO. 625 S Wolfe st., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~yes~~

6 DATE OF BIRTH (month, day, and year) unknown 1885

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Eater. 040
(b) General nature of industry, business, or establishment in which employed (or employer) WM. S. SCHLUDERBERG
(c) Name of employer T. J. KURDLE, Co.

9 BIRTHPLACE (city or town) Poland.
(State or country)

PARENTS

10 NAME OF FATHER unknown Tunski

11 BIRTHPLACE OF FATHER (city or town) Poland.
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland.
(State or country)

14 Informant Stanislaw Wlodarczyk
(Address) 2034 E Pratt St.

Filed 19 [illegible] Registrar

JUL 3 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as ~~follows~~: Heat Prostration

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? T J Kurdle Co

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cemetery — DATE OF BURIAL: July 5 1930

20 UNDERTAKER: George A. Weber — ADDRESS: 709 S Ann St.

Cor. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58514

REGISTERED NO. 4

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 255 E. Hamburg St. St., 24-33 Ward)

2-FULL NAME Michael J. Hick.

(a) RESIDENCE NO. 255 E. Hamburg St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	72	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Hick.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Barbara Ebelein.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Mary A. Baumgarten. (sister)
(Address) 715 Hanover St.

15 Filed C. HAMPSON JONES, M. D. Registrar

JUL 3 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardiat Insufficiency.

Acute Dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Charles Reinhardt, M. D.

7/2, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a. d. Co.

DATE OF BURIAL 7/5/1930

UNDERTAKER William Cook

ADDRESS 1217 Park

Boxes should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

58515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 58515

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 N. Lemwood Ave ST. 6-11 WARD)

2-FULL NAME Bessie Lillie

(a) RESIDENCE NO. 203 N. Lemwood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 30-1905

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	25	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Home

9 BIRTHPLACE (city or town) (State or country) Sparrows Point. Md.

PARENTS

10 NAME OF FATHER Wm George Lillie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Edith Croppes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs Edith Lillie
(Address) 203 N. Lemwood Ave

15 Filed JUL 3 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1929. to July 2, 1930.

that I last saw her alive on July 2, 1930.

and that death occurred, on the date stated above, at 11.45 P. m. (D.S.T.)

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis, Cardiac hypertrophy + dilatation, generalized anasarca, Subacute nephritis.

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clin. data.

(Signed) Fechheimer M. D.

, 19 (Address) 3034 Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn — DATE OF BURIAL July 6 1930

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

Monjuger 800 E North Ave

E 58516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 58516

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 Barclay ST. 12-14 WARD)

2-FULL NAME Sarah Ellen Hamilton

(a) RESIDENCE No. 1803 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Thos. D. Hamilton

6 DATE OF BIRTH (month, day, and year) Feb 25-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ax Hones

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Brauzell

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Maisel Benton (Address) 902 Snyder Ave

15 Filed JUL 2 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2-1930

17 I HEREBY CERTIFY, That I attended deceased from June 20th, 1930, to July 2, 1930, that I last saw h alive on July 2, 1930, and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Apoplexy (duration) — yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Arthur C Monninger M. D.

7/2, 1930 Address 800 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery

DATE OF BURIAL 7/5 1930

20 UNDERTAKER William Cook

ADDRESS 217 St Paul

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58517

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 E 58517

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) NO. 1322 Highland ave ST., 26-1 WARD)

2-FULL NAME John Henry Meyers.

(a) RESIDENCE NO. 1322 Highland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced HUSBAND) of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry J Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Edith R Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Henry Meyers (Address) 1322 Highland ave

15 Filed ..... 19 ..... Registrar

C. HARRISON JONES M. D.

JUL 3 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-2-30

17 I HEREBY CERTIFY, That I attended deceased from 7-1, 19 30, to 7-2, 19 30, that I last saw h[illegible] alive on 7-2, 19 30, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows: Prematurity Birth

Asphyxia Neonatorum

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) [illegible] M. D.

(Address) 100 W Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel July

DATE OF BURIAL 3 1930

20 UNDERTAKER John M Weber ADDRESS 401 S. Chester st

IMPORTANT. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58518

CERTIFICATE OF DEATH

65-001 E 58518

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospitals St. 8-17 Ward)

2-FULL NAME Henry Conrad

(a) RESIDENCE NO. 1821 N Carolina St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma L. Conrad

6 DATE OF BIRTH (month, day, and year) May 31 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	74	1	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Cabinet maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Peter Conrad

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Schabe

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Emma L. Conrad
(Address) 1731 Rutland ave

15 Filed JUL 3 1930 C. HAMPSON JONES, M. D. Registrar
By Asst

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Lymphatic Leucaemia
(Hospital report)
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? 1821 N Carolina
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) James M Fenlon M. D.
7/3. 1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL July 4 1930

20 UNDERTAKER Robert J Turner — ADDRESS 942 N Broadway

Filed JUL 3 1930

Have undertaker carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 58519

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58519

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2302 E. Preston St. ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles King Kretchmer

(a) RESIDENCE NO. 2302 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Kretchmer

6 DATE OF BIRTH (month, day, and year) Oct. 3 - 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired do

(b) General nature of industry, business, or establishment in which employed (or employer) Wagon Foreman

(c) Name of employer American Railway Express Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John Kretchmer

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline King

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant Charles K. Kretchmer Jr

(Address) 2302 E. Preston St.

15 Filed 3 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-2-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 -, 1925, to 7-2-, 1930, that I last saw h alive on 6-30-, 1930 and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs & symptoms.

(Signed) Chester Riland, M. D.

7-2-, 1930 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL July V 1930

20 UNDERTAKER Chas. G. Black — ADDRESS 942 W North ave

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 58520 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58520

CERTIFICATE OF DEATH.

74 001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2627 N. Charles (Ward) 47-49

2-FULL NAME Ella Howard Hobbs

(a) RESIDENCE NO. 2627 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 19 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Bruce Howard Hobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Mary White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Philadelphia Pa

14 Informant Miss Mollie T. Hobbs

(Address) 2627 N. Charles St

15 Filed ....., 19.... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1930

17 I HEREBY CERTIFY, That I attended deceased from July, 1930, to July 3, 1930, that I last saw h[illegible] alive on July 3, 1930, and that death occurred, on the date stated above, at 6.55 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy - 6 hours

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno Hampson Jones M. D.

7/3, 1930 (Address) 410 Med. Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery DATE OF BURIAL: July 7 1930

20 UNDERTAKER: Chas. S. Black 1412 W. Fayette Ave ADDRESS

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58521

CERTIFICATE OF DEATH

90 ✓ E 58521

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1827 Riggs Av ST. 16-27 WARD)

2—FULL NAME Caroline Friedicka Traband

(a) RESIDENCE NO. 1827 Riggs Av ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word): Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of: George Traband

6 DATE OF BIRTH (month, day, and year): Oct 4th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Emil King

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Ehrman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Burline Traband

(Address): 1827 Riggs Av

15 Filed 3-1930 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930 to July 3, 1930, that I last saw h[illegible] alive on July 3, 1930 and that death occurred, on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

Myocarditis.

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary edema

..... (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Phys. Examination

(Signed) Fortus L. Baggoth M. D.

, 19 (Address) 2229 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	7/7/ 1930
20 UNDERTAKER	ADDRESS
[illegible] Bork	1217 St Paul St

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 58522.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58522

CERTIFICATE OF DEATH.

129 E 58522

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807 N. Payson St. ST.) 15-21 (WARD)

2-FULL NAME Wolfe Paymer

(a) RESIDENCE NO. 1807 N. Payson ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blume Paymer

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Paymer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Paymer Bros (Address) 1807 N Payson St

15 Filed 4 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/3/30

17 I HEREBY CERTIFY, That I attended deceased from 3/28, 1930, to 7/3, 1930, that I last saw h[illegible] alive on 7/3/30, 19..., and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular Renal disease

(duration) ...yrs. ...mos ...ds.

CONTRIBUTORY (Secondary) (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Benjamin Samber M. D.

, 19 (Address) 5128 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herman Rom

DATE OF BURIAL July 4, 1930

UNDERTAKER D. Jack Lewis ADDRESS 1439 E Baltimore St

TION is very important: See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

Dr Fleming
203 Inglefield Ct.

E 58523

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 58523

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 S. Chapel St. WARD) 12-250

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjiman King

(a) RESIDENCE NO. 2118 W Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Oct 19 1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs C Oldfield

(Address) 2132 W. Lafayette St

15 Filed JUL 4 1930 G. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 2, 1930, that I last saw h.....alive on July 2, 1930, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. G. Fleming, M. D.

7/2, 1930 (Address) Catonsville Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL July 5 1930

20 UNDERTAKER W M Cook — ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58524

CERTIFICATE OF DEATH.

58524

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3735 Brooklyn St. or WARD) 25-75

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Mailey

(a) RESIDENCE NO. 3735 Brooklyn ST. Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Mailey

6 DATE OF BIRTH (month, day, and year) April 3 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Thomas Mailey

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Martha Rutledge

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Martha E. Smeard (Address) 3735 Brooklyn Ave.

15 FILED 4 JUL 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to July 3, 1930, that I last saw her alive on July, 1930 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Thrombosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) H. S. Campbell M. D.

July 3 1930 (Address) 1674 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	July 5 1930
20 UNDERTAKER	ADDRESS
M. W. E. Hoppel Inc	51 Lamb

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58525

CERTIFICATE OF DEATH.

E 58525 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 4000 (Street) Groveland Ave (Ward) 15-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mark Campbell

(a) RESIDENCE NO. 4000 Groveland Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE Edgar Campbell

6 DATE OF BIRTH (month, day, and year) 4/25/1906

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	24	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 057

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Peter McKnight

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Margaret Eastman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs. Peter McKnight

(Address) 4000 Groveland Ave

Filed JUL 4 1930 C. HAMILTON JONES, M. D. Registrar

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3, 1930 19

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1930, to July 3, 1930, that I last saw h[illegible] alive on July 2, 1930, and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) 0 yrs. 0 mos. 15 ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage

(duration) 0 yrs. 0 mos. 0 ds. 1 hr.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Blood Test.

(Signed) Chas. S. Hentwadt, M. D.

, 19 (Address) 1730 Linden ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Date of Burial 7/5 1930

20 UNDERTAKER F. Sahlhorne ADDRESS 1818 Eighty

THE CAUSE OF DEATH must be stated plainly. Avoid use of terms like "Heart Failure," "Exhaustion," "Blood Poisoning," etc., as the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 58526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103 E 58526

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp ST. 16-26 WARD)

2-FULL NAME Jno N. Gantt

(a) RESIDENCE NO. 641 N Calhoun ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cassie Gantt

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50		0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer Cald't & Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Peter Gantt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lydy Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Nelson

(Address) 641 N Calhoun

15 Filed ..... 19 ..... Registrar

1930 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/1 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Walked into side of moving auto.

(a) ..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Fract Skull (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Ridgley & Conway Sts

Did an operation precede death? yes Date of 6/30/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Surg.

(Signed) J. J. Strauss, M.D. Coroner

7/3 19 30 (Address) 64 39th & Elderslie

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooks [illegible] DATE OF BURIAL July 4, 30

20 UNDERTAKER Cald & Co Inc ADDRESS 1027 Mad Ave

John H. Toadvine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 58527

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58527

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Home for Incurables St., 13-52 WARD)

2-FULL NAME Johnetta B Sanger

(a) RESIDENCE No 2902 2. St Wash. D C St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	W. dowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Geo H. Sanger

6 DATE OF BIRTH (month, day, and year) Apr 6-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	2	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work R. N.
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jno F Brockenborough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Frances Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant

(Address)

15 Filed ..... 19 ..... C. HANSON JONES, M. D. Registrar

4-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck & Knocked down by moving auto

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fract Skull - Confusion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Chas St & Mass Ave N W

Did an operation precede death? Yes Date of 2-10-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Surgical

(Signed) Dr Frame, M. D. Coroner

7/4, 1930 (Address) 2934 Mt Eddy Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	7/4 1930
20 UNDERTAKER W. F. Bruce for Wm Isaac Bird	ADDRESS Wash. D.C.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 58528

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58528

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4032 Roland ave. St., 13-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harvey Brooks Baldwin (40 yrs., 5 mos., 19 ds.)

(Residence in Baltimore: No. 4032 Roland ave. St.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: January (Month) 13 (Day) 1890 (Year)

7-AGE: 40 yrs. 5 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Surgery & Obstetrics (b) General nature of industry, business, or establishment in which employed (or employer): Dr.

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Samuel C. Baldwin

11-BIRTHPLACE OF FATHER, (State or Country): Baltimore Md.

12-MAIDEN NAME OF MOTHER: Mary Ellen Whitt

13-BIRTHPLACE OF MOTHER, (State or Country): Annapolis Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary E. Baldwin

(Address) 2118 N. Charles St.

15- Filed 5-7-1930 C. HAMPSON JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 2 (Day) 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Obstruction of Heart

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) [signature] M. D. (Coroner.)

7/2/1930 (Address) 2612 Roland ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Woodlawn Cem. DATE OF BURIAL. July 5 1930

20-UNDERTAKER. F. J. Tuckner & Sons ADDRESS 1 W. Lafayette

If the cause of death is not plain, write so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58529 ✓ E 58529

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Jenkins Memorial Hospital X 129 REGISTERED NO. 75-72

CITY OF BALTIMORE: (No. 1000 Caton Ave S. 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Everett Warner

(a) RESIDENCE NO. 111 Rosewood Ave ST., WARD

(Usual place of abode) Catonsville.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Hooper Warner

6 DATE OF BIRTH (month, day, and year) Mar 1, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Chas. E. Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Wilkes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Jenkins Memorial Hosp. 1000 Caton Ave

15 C. HAMPSON JONES, M. D. 19 July 5 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1930

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1930, to July 5, 1930, that I last saw him alive on July 5, 1930, and that death occurred, on the date stated above, at 5 45 p. m.

The CAUSE OF DEATH* was as follows:

Right Hemiplegia

Cardio-Vascular-Renal disease

Terminal pneumonia

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) C. H. Jones, M. D.

19 (Address) 1000 Caton Ave. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL July 5 1930

20 UNDERTAKER Wm. J. Heckrotte Sons ADDRESS Morrell Pk

5 - 1930

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 58530

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58530

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Catonsville Ave. St. 28-71 WARD)

REGISTERED NO. 117

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lou Newell

(a) RESIDENCE NO. 4225 Old Frederick Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31, 1925

7 AGE: Years 4 Months 6 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER C. Leroy Newell

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Keen

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant C. Leroy Newell (Address) 4225 Old Frederick Rd

15 Filed JUL 5 -1930 H. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-2. 1930. to 7-4. 1930.

that I last saw h alive on 7-1. 1930.

and that death occurred, on the date stated above, at 2.45 P m. E.S.T

The CAUSE OF DEATH* was as follows:

Acute appendicitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute Peritonitis Streptococci

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Relay, Md.

Did an operation precede death? Yes Date of 7-2-30

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W Harrison M. D.

July 4 1930 (Address) Halethorpe, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL July 7 1930

20 UNDERTAKER Ralph Cook

ADDRESS 1003 West Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 58531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 58581

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 21-31 WARD)

2-FULL NAME Arthur L. Rossbach

(a) RESIDENCE NO. 547 West West ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Anna Pearl Rossbach

6 DATE OF BIRTH (month, day, and year) June 19, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	-	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Sh

(c) Name of employer American Eng. Co.

9 BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10 NAME OF FATHER Edward Rossbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Pearl Rossbach

(Address) 547 West West St.

15 Filed JUL 5 - 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1930

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1930, to July 2, 1930, that I last saw h alive on July 2, 1930, and that death occurred, on the date stated above, at 12:55 P m.

The CAUSE OF DEATH* was as follows:

Streptococcus infection, General

Endocarditis

(duration) yrs. 1 mos 17 da.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis Terminal

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? None Date of —

Was there an autopsy? No

What test confirmed diagnosis? Streptococcus Hemolyticus Found in Blood Culture

(Signed) Henry [illegible] M. D.

7/2, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glen Hill Cem

20 UNDERTAKER [illegible] Cook

DATE OF BURIAL July 5 1930

ADDRESS 1003 West Baltimore St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58532

CERTIFICATE OF DEATH

129 E 58532

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1432 N. Union St., 15-21 Ward)

2-FULL NAME Harry Carter

(a) RESIDENCE NO. 1432 N. Union St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred S/F yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Carter

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 50 | Months | Days | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 540
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md

PARENTS

10 NAME OF FATHER: Jasper Carter

11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)

12 MAIDEN NAME OF MOTHER: Rilla Queen

13 BIRTHPLACE OF MOTHER (city or town): Md
(State or country)

14 Informant: Parker Carter
(Address): 1432 N. Union

15 Filed 5-1-1930 C. HAMPSON JONES M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and hour): July 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) 3rd [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: 7/5 1930

20 UNDERTAKER: Thomas E. Kelson

ADDRESS: 303 Preston St

54

Should be carefully supplied. AGE should be stated EXACTLY. If UNDER ONE DAY OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 58533

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58533

REGISTERED NO. 117

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. General Hospital ST. 20-69 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah A. Clark

(a) RESIDENCE NO. 23 Saman Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Black

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER John Purvis

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Henrietta Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Hospital records

(Address)

15 Filed 5-1930, 19 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-2-30

17 I HEREBY CERTIFY, That I attended deceased from 6-29, 1930, to 7-2, 1930, that I last saw her alive on 7-2, 1930, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

Ovarian Cyst

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 6-29-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Talbot V. Chesnutt, M. D.

7/3, 1930 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 7-5 1930

20 UNDERTAKER Robert Brooke & Son

ADDRESS Calhoun & Hollins

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58534 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58534

CERTIFICATE OF DEATH.

× 31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 76 WARD 27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Melvin Lomax

(a) RESIDENCE NO. Cherry Heights, Overlea, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

[redacted]married, widowed, or divorced HUSBAND of (or) WIFE of Florence

6 DATE OF BIRTH (month, day, and year) Jan. 3, 1910

7 AGE	Years	Months 6	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 040

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Lomax

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Rebecca Lomax

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address) B.C.H.

15 Filed 5 1930, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1930, to July 3, 1930,

that I last saw him alive on July 3, 1930,

and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

indefinite

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [signature] M.D.

7-3, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Ct

DATE OF BURIAL July 5 1930

20 UNDERTAKER H. L. Brauns Son

ADDRESS Govans, Md.

FOR IS Very Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58535 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58535

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto. City Hosp. 23-31 (WARD)

CITY OF BALTIMORE: (No. ST.

2-FULL NAME Robert Walker

(a) RESIDENCE NO. 909 Plum alley ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mary Walker

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attendant

(b) General nature of industry, business, or establishment in which employed (or employer) Refining Sugar

(c) Name of employer Amer. Sugar Refg. Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Walker

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Md.

14 Informant Mrs. Russ

(Address) Balto City Hosp

Filed JUL 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-3-30

17 I HEREBY CERTIFY, That I attended deceased from 6-28, 1930, to 7-3, 1930, that I last saw him alive on 7-3, 1930, and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerotic cardio-renal disease.

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Gangrene of left leg (duration) yrs. 6 mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? yes Date of 7-2-30

Was there an autopsy? no.

What test confirmed diagnosis? Clinical Exam.

(Signed) Fred M. Duckwall, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct DATE OF BURIAL July 6 1930

20 UNDERTAKER W. L. Brown & Son ADDRESS Vol. & Monty

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58536

CERTIFICATE OF DEATH

185 E 58536

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 742 George St. 17-2 Ward)

2-FULL NAME Eugene Lockett

(a) RESIDENCE NO. 742 George St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country) "

PARENTS

10 NAME OF FATHER Wm Lockett
11 BIRTHPLACE OF FATHER (city or town) Va
(State or country) "
12 MAIDEN NAME OF MOTHER Ida Gruden
13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country) "

14 Informant Ida Lockett
(Address) 742 George St

15 Filed 1930 C. HANSON JOYCE M. D.
Per ACH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The Cause of Death was as follows:
Fractured Skull
Fall
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Fall off Steps
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Autopsy
(Signed) C. Hanson Joyce, M. D.
July 1 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel Cemetery
DATE OF BURIAL July 3 1930

20 UNDERTAKER Samuel A. Krug
ADDRESS 758 Edmondson Ave

5

DO NOT SHOW BE CARELESS OR INCOMPLETE. DO NOT SHOW BE ABBREVIATED. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58537 ✓ E 58537

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1013 S Hanover ST. 23-23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence S. Scott

(a) RESIDENCE NO. 1013 S Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Marie Scott

6 DATE OF BIRTH (month, day, and year) Nov. 18- 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel V. Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret E. Burdette

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Henry Scott (Address) 1013 S Hanover St.

15 Filed JUL 5 1930, 19 Per C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 6th, 1930 to July 3rd, 1930, that I last saw h~~im~~ alive on July 3rd, 1930, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of testicle with general metastasis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Carcinoma cachexia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb 19th 1930

Was there an autopsy? No

What test confirmed diagnosis? Operation + x-rays

(Signed) Harry Weibel, M. D.

7/4, 1930 (Address) 1034-26 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem.

DATE OF BURIAL July 7th 1930

20 UNDERTAKER D. A. Krause & Son

ADDRESS 703 Hanover St

TION is very important See instructions on back of certificates.

L 5 - 1930

Spec.—1-10-21—M&T—1500 Blks.

E 58538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-21 E 58538

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1838 Forrest St. (St.) 10-15 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Moylan

(a) RESIDENCE NO. 1138 Forrest St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eleanor Moylan

6 DATE OF BIRTH (month, day, and year): July 5th. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Deputy Sheriff.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: John Moylan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mrs. Eleanor Moylan, 1138 Forrest St.

15 Filed 1930 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 4th. 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1930, to July 4, 1930, that I last saw h[e] alive on June 19, 1930, and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Acute Hemorrhage Sudden. (Oral)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Levy, M. D.

7/5/30 (Address) 800 N Broadway St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery.

DATE OF BURIAL: 7/7. 1930

20 UNDERTAKER: Wade H. Frank & Son

ADDRESS: 1800 N Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

L 5

Spec.—1-30—M. & T.—250 Blks

E 58539

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58539

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 2-4 ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Semski

(a) RESIDENCE NO. 1816 Fleet St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ..... mos. ..... da. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frances

6 DATE OF BIRTH (month, day, and year) Aug. 19, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	55	10	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) 06
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Lorenz Semski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Records of
(Address) Balto. City Hospitals

Filed JUL 5 - 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-3-30

17 I HEREBY CERTIFY, That I attended deceased from 6-23-30, 19..., to 7-3-30, 19..., that I last saw him alive on 7-3-30, 19..., and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Abscess of lung

(Not tuberculous)

(duration) ..... yrs. 7 mos ..... da.

CONTRIBUTORY (Secondary) Myocarditis. CHRONIC UNKNOWN. (duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical gram; X-ray

(Signed) Paul Padget, M. D.

7-3-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus DATE OF BURIAL July 7 1930

20 UNDERTAKER F. W. Ozgewski ADDRESS 1931 Eastern Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58540

E 58540

CERTIFICATE OF DEATH

REGISTERED NO. 117

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST. 28-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida M. Hill

(a) RESIDENCE NO. 307 Chapel Gate Lane ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Hill

6 DATE OF BIRTH (month, day, and year) July 29, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Housewife~~ Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York, Pa.

PARENTS

10 NAME OF FATHER Wm. Pearce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hospital records

15 Filed 5-7-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th, 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-5-, 1930, to 7-4-, 1930, that I last saw her alive on 7-4-, 1930, and that death occurred, on the date stated above, at 5-15 a.m.

The CAUSE OF DEATH* was as follows:

General peritonitis, following Ruptured gangrenous appendix

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 7-2-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert F. Chenoweth, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL July 7 1930

ADDRESS 715 Light St

20 UNDERTAKER John D. Dennis

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 58541 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58541

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 96-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hoblitzel

(a) RESIDENCE NO. Balto. City Hosp. Infirmary ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Hobletson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Records of Balto. City Hospitals

Filed ... 1930 ... 19 C. HAMPSON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30-30

17 I HEREBY CERTIFY, That I attended deceased from 4-3-30, 19..., to 6-30-30, 19...

that I last saw him alive on 6-30-30, 19...

and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, unknown. (duration) yrs. mos. ds.

CHRONIC

18 Where was disease contracted if not at place of death? Hospital.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Podgat. M. D.

7-3, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL July 5 1930

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

TION is very important. See instructions on face of certificate.

Spec.—1-30—M. & T.—250 Blks

E 58542

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58542

CERTIFICATE OF DEATH.

117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hospital) 9-47 (WARD)

2-FULL NAME Francis R. Evans

(a) RESIDENCE NO. 515 East 35th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John W. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Frances Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Father.

(Address) As above.

Filed JUL 5 - 1930 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 4th, 1930, to July 5th, 1930, that I last saw h.. alive on July 5th, 1930, and that death occurred, on the date stated above, at 12:15 a.m.

The CAUSE OF DEATH* was as follows: D. S.

Appendicitis acute, with abscess formation.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 4

Was there an autopsy? No

What test confirmed diagnosis? Explor. Laparotomy

(Signed) Samuel McLanahan, M. D.

July 5, 1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL July 7 1930

ADDRESS 7:5 Light

20 UNDERTAKER John F. Denny

TION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 58543

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58543

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Univ Hosp St. (or WARD) 4-30

2-FULL NAME Benj. Franklin Brown

(a) RESIDENCE NO Laurel Md St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 1 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Brown

6 DATE OF BIRTH (month, day, and year) Oct 31-187[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	8	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Constable
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Prince's Gen. Contr.

PARENTS

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Jas N. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary L. Shorts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant [illegible]

(Address)

15 Filed 5-1930 Per ... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

18 CAUSE OF DEATH* was as follows: Auto upon which he was riding had head on collision with truck while on wrong side of Road - (a) (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) ... yrs. ... mos. ... ds.

Brain Confusion

Where was disease contracted if not at place of death? Wash Blvd at Laurel Md

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. J. Frame, M. D. Coroner

7/5 1930 (Address) 293 Main St Laurel Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md

DATE OF BURIAL 7/7/1930

20 UNDERTAKER L Floyd Rainer

ADDRESS Laurel Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. PART I. NATURE OF DISEASE

TION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 58544

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58544

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2635 N. Charles St. Ward 17-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. McNaney-

(a) RESIDENCE No. 2635 N. Charles St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs.— mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James McNaney-

6 DATE OF BIRTH (month, day, and year) June 16, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none—

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER George B. Ashby-

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va-

12 MAIDEN NAME OF MOTHER Chamblin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va-

14 Informant Mrs. E. F. A. McNaney

(Address) 2635 N. Charles St.

15 Filed 5-7-1930 C. HAMPSON JONES, M. D., Registrar.

By MH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1930, to July 4, 1930, that I last saw her alive on July 4, 1930, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical symptoms

(Signed) Wm. M. Ramsey Baker, M. D.

, 19 (Address) 2740 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL July 7 1930

20 UNDERTAKER H. M. Routson — ADDRESS 223 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

5 - 1930

Spec.—1-30—M. & T.—250 Bks

E 58545

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58545

33

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Provident Hospital ST. 10-14 (WARD)

2-FULL NAME Louise Shannon

(a) RESIDENCE No. 1012 E Madison ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	12			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) [redacted] N.C.
(State or country) Charlett N.C.

PARENTS

10 NAME OF FATHER William Shannon
11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) S.C.
12 MAIDEN NAME OF MOTHER .....
13 BIRTHPLACE OF MOTHER (city or town) S.C.
(State or country)

14 Informant Leara Thompson
(Address) 1012 E Madison

15 Filed 5 1930 19..... C. HAMPSON JONES, M. D. Registrar
No. 8677

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-3-30

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1930, to July 3, 1930, that I last saw her alive on July 3, 1930, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:
Tuberculus Peritonitis
(duration) unknown yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) B. F. Harris, M. D.
7/3, 1930 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Asbury Cem.

DATE OF BURIAL
5-6 1930

20 UNDERTAKER Byron & Knight 1218 N. Caroline St.
ADDRESS

TION IS very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58546

E 58546

CERTIFICATE OF DEATH.

101-01

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1541 Orleans ST. 6-9 (WARD)

2-FULL NAME Mary Carter

(a) RESIDENCE No. 1541 Orleans ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Wd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eli Carter

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Magothy Arundel Co
(State or country) Md

PARENTS

10 NAME OF FATHER Robert Hall

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Melvina Reese

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Carrie Gibson
(Address) 1038 Eastland Ave.

15 Filed JUL 5 1930, 19 C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2-30

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1930 to July 2, 1930, that I last saw h[illegible]ive on July 2, 1930, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. 4 ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. S. Allen M. D.

(Address) 1508 Eutaw Pl 7-2 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Magothy Arundal Co. Md

DATE OF BURIAL 7-6 1930

UNDERTAKER Byron Wright

ADDRESS 1218 N. Calvert St.

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58547

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58547

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 S. Hanover St. 23-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis A. Smith

(a) RESIDENCE NO. 1212 S. Hanover St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Lula A.(nee Wilkinson)

6 DATE OF BIRTH (month, day, and year) April 9, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Frank B. Smith (Address) 218 Mallow Hill Rd.

15 Filed 5 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd 1930

17

I HEREBY CERTIFY, That I attended deceased from June 23rd, 1930, to July 3rd, 1930.

That I last saw him alive on July 3rd, 1930,

and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia following acute bronchitis

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(duration) — yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) C. Fonry Fleibel, M. D.

7/5, 1930 (Address) 1224-26 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL 7/5/30 19

20 UNDERTAKER Harry N. Mitzel, 4101

ADDRESS Edmondson Ave

TION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

E 58548

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58548

CERTIFICATE OF DEATH.

24-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3206 Evergreen ave ST. 27-43 WARD)

2-FULL NAME Raymond Fuld.

(a) RESIDENCE NO. 3206 Evergreen ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 3 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (~~wife of~~) ~~Rose Lee Miller~~ Fuld

6 DATE OF BIRTH (month, day, and year) March 13th 1874

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
56.	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Jacob Fuld

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Abel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U.S.

14 Informant: Mrs Lillie Fuld
(Address) 3206 Evergreen ave

15 7-1930, 19.. C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th 1930

17

I HEREBY CERTIFY, That I attended deceased from June 27, 1930 to July 4, 1930.

that I last saw him alive on July 4, 1930.

and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

June 29-July 4 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) George C. E. Vogler, M. D.

July 4, 1930 (Address) 3000 Hamilton ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: July 7th 1930

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Hamilton st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 58549

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58549

CERTIFICATE OF DEATH

49 X

REGISTERED NO. 12-50

1—PLACE OF DEATH U.S. Marine Hospital,

CITY OF BALTIMORE: (No. Baltimore, Md. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry W. Carter

(a) RESIDENCE NO. Fayette City, Pa. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

Important. See instructions on back of certificates. Carter 4 Mar 26

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 19, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	2	14 15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer SS Chickasaw City

9 BIRTHPLACE (city or town) Pennsylvania
(State or country)

PARENTS

10 NAME OF FATHER Louis Carter

11 BIRTHPLACE OF FATHER (city or town) Penna.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret McMechen

13 BIRTHPLACE OF MOTHER (city or town) Penna.
(State or country)

14 Informant Records, U.S. Marine Hospital
(Address) Baltimore, Md.

15 Filed JUL 5 1930, 19 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 27th, 1930, to July 4th, 1930, that I last saw him alive on July 4th, 1930, and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma with metastasis.

(duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis (duration) undetermined yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? none here Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Laboratory

(Signed) Gordon A. Abbott M. D.

7/5, 1930 (Address) U.S. Marine Hospital, Balto., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Newton Pa	July 5 1930
20 UNDERTAKER	ADDRESS
Wm C. Miller & Son	E Oliver

Spec.—1-30—M. & T.—250 Blks

Dr Von Schultz — 4518 Edmondson Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58550 — REGISTERED NO. E 58550

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3215 Old Annapolis Rd St.) (WARD) 25-7 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Guethlein

(a) RESIDENCE No. 3215 Old Annapolis Rd St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Emma T. Guethlein

6 DATE OF BIRTH (month, day, and year) 3/14/1859

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Guethlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma T. Guethlein

(Address) 3215 Old Annapolis Rd

15 Filed JUL 6 1930 19 RAC Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to July 4, 1930; that I last saw h alive on July 4, 1930; and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis & Endocarditis

(duration) Several Years

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Augustus P. Von Schultz M.D.

(Address) 4518 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL 7/8/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 E Pratt St

TION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 58551

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 58551

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~2548 Polk St~~ Rear Room of ST. 9-46 WARD)

2-FULL NAME George Andrew Morrison

(a) RESIDENCE NO 2660 Kennedy Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ellen Morrison

6 DATE OF BIRTH (month, day, and year) Feb 11/1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	4	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 030
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER William Morrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Ellen Myers
(Address) 2724 E. Chase St

15 Filed 6-6 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Valvular Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Alcoholism
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ..... Coroner, M. D.

7/5/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL 7/7 1930

20 UNDERTAKER Wm Cook — ADDRESS 127 St Paul St

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

Dr Brooks 3rd st Brooklyn

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58552

CERTIFICATE OF DEATH.

74-081

E 58552

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 Patapsco ST. Brooklyn 25-75 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis C. Anderson

(a) RESIDENCE NO. 422 Patapsco ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~
~~HUSBAND~~ of
(or) WIFE of Andrew J. Anderson

6 DATE OF BIRTH (month, day, and year) 6/6/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Prince George Co.

PARENTS

10 NAME OF FATHER Jerome Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George Co

12 MAIDEN NAME OF MOTHER Eliza M Manley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince George Co

14 Informant George C Anderson
(Address) 422 Patapsco St

15 Filed JUL 6 1930 C. HARRISON JONES, M. D. Registrar
By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/4/30

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 4, 1930, that I last saw h... alive on July 3, 1930, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Gen. Debility

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooks M. D.

July 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 7/7/1930

UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

Dr Denby 3522 Greenmount Ave
Main 2312 ✓

E 58553 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 58553

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4428 Wrenwood Av ST.) 27-47 (WARD)

2-FULL NAME Julia King Jones

(a) RESIDENCE NO. 4428 Wrenwood Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Divers H. Jones

6 DATE OF BIRTH (month, day, and year) April 11th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	68	14	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm B Murdock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth K. Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Divers H. Jones
(Address) 4428 Wrenwood Ave

15 Filed JUL 6 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1929, to July 3, 1930, that I last saw her alive on July 3, 1930 and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John L Jones, M. D.

7/4, 1930 (Address) 3522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Locust Grove Cem Annapolis Md

DATE OF BURIAL 7/7/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

CAUSE OF DEATH must be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

UL 6 - 1930

Spec.—1-30—M. & T.—250 Blks

Dr. Nelson 1303 W. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

58554

CERTIFICATE OF DEATH.

90

E 58554

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2710 W. North Ave ST., 15-68 WARD

2-FULL NAME Barbara Schnaufer

(a) RESIDENCE NO. 2710 W. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of John Schnaufer

6 DATE OF BIRTH (month, day, and year) Aug 7th 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo Schnaufer

(Address) 2409 Poplar Drive

15 [illegible] JONES, M. D. Registrar

JUL 6 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1930, to July 4, 1930, that I last saw h[illegible] alive on 7 4, 1930, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular disease of the heart

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Leo A. Nelson, M. D.

, 19 (Address) 1303 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 7/7/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT NAME OF DISEASE. TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58555 (registered no.)

E 58555

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Garage rear of 620 Wyndhurst Ave ST., 12-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cyrus R. Meyer

(a) RESIDENCE NO 2041 Guilford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Janet Meyer

6 DATE OF BIRTH (month, day, and year) Dec 25/ 1865-7

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62 or 64	6	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None-Formerly
(b) General nature of industry, business, or establishment in which employed (or employer) Buyer for
(c) Name of employer Brager-Eisenberg Co

9 BIRTHPLACE (city or town) (State or country) Easton, Pa.

PARENTS

10 NAME OF FATHER Abram Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Lentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jacob. R. Meyer (Address) 2935 N. Franklin St., Phila. Pa.

15 Filed JUL 6 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Tenative Carbon Monoxide Poisoning
(Final cause of death will be made after report of chemical analysis)
Postby (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? By Dr. H.J. Maldeis

What test confirmed diagnosis?

(Signed) [signature] Coroner, M. D.

7/5/30 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa

DATE OF BURIAL 7/6/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

CAUTION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 58556

58556

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Home for the Aged M. E. Church Ward)

2-FULL NAME anna Rebecca Baker

(a) RESIDENCE NO. Fallsway & Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Baker

6 DATE OF BIRTH (month, day, and year) Aug 20, 1836

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	93	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Calvert Co

PARENTS

10 NAME OF FATHER Nathan Ogden

11 BIRTHPLACE OF FATHER (city or town) Pittsburgh (Pa)

12 MAIDEN NAME OF MOTHER Eliza Chambers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Calvert Co

14 Informant Miss Etta Tatty

(Address) 1536 Madison St

15 Filed JUL 6 1930 C. H. WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 — 1930

I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to July 4 1930, that I last saw h alive on July 4 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Cardio-Vascular disease

(duration) 30 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 1 ds.

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm Love, M. D.

, 19 (Address) 836 W Mont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial July 7, 1930

20 UNDERTAKER George J. Smith Holliday H

ADDRESS 1522

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 58557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9° E 58557

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2842 Parkwood ST. 59 WARD

2-FULL NAME Max Moses

(a) RESIDENCE NO. 2842 Parkwood ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of late Celia

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	—	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nail

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Baer Moses

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rifka —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jos Moses
(Address) 2842 Parkwood ave

15 Filed JUL 6 - 1930 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5/30

17 I HEREBY CERTIFY, That I attended deceased from July 1 - 1930, to July 5 1930, that I last saw h[illegible] alive on July 5 1930, and that death occurred, on the date stated above, at 1:15 A m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ... yrs. ... mos. 4 hrs

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) N. J Dandad, M. D.

7/6 1930 (Address) 3035 Odonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd. | DATE OF BURIAL July 6 1930

20 UNDERTAKER Jos Levinson & Bro | ADDRESS 1127 E Balto st

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

58558

179-001 ✓ E 58558

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto Gen. Hosp St. 24-36 Ward

2-FULL NAME Evelyn Petroff

(a) RESIDENCE NO. 1409 Hanover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 6. 1933

7 AGE: Years 4 | Months | Days 28 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Christ Petroff

11 BIRTHPLACE OF FATHER (city or town) Bulgaria
(State or country)

12 MAIDEN NAME OF MOTHER Cath. McKnew

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mr Cath. Petroff
(Address) 1409 Hanover St

15 Filed [illegible] 1930 G. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4. 1936

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gen. Burns. Left side body
Caused by bullet wound "Sparkler"
Hanover (duration) yrs. mos. da.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. [illegible] M. D.

July 5 1930 (Address) 1634 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: 7/7/36

20 UNDERTAKER: Chas. L. Stevens — ADDRESS: 15 E Fort

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58559 ✓ 90 E 58559

CERTIFICATE OF DEATH.

REGISTERED NO.

E 58559

1-PLACE OF DEATH Baltimore City Hospitals ST. 9-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME William T. Wells

(a) RESIDENCE NO. ? 1925 E. 32nd St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. 6[illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 10/21/1847

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	82	8	14	X

8 OCCUPATION OF DECEASED Clerk

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 6-1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-5-30

17 I HEREBY CERTIFY, That I attended deceased from 7-20-25, 19..., to 7-5-30, 19...,

that I last saw h... in life on 7-5-30, 19...,

and that death occurred, on the date stated above, at 2:35 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

toxic

(duration) 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) unknown yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Hosp.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Paul Padget, M. D.

7-5, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet

DATE OF BURIAL 7/7/30

20 UNDERTAKER Woodlawn Co.

ADDRESS 1735 Harford Ave

TION IS very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 58569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 58560

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 602 W. Conway St. Ward 12-30)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Miller

(a) RESIDENCE NO. 602 W Conway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 53 Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co Md

(State or country)

PARENTS

10 NAME OF FATHER Ed. Blake

11 BIRTHPLACE OF FATHER (City or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant (Address) Tempy Butler 602 W. Conway St

15 Filed JUL 6 1930 CHARLES JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1 1928, to July 2 1930, that I last saw her alive on July 1st 1930, and that death occurred, on the date stated above at 8 00 m.

The CAUSE OF DEATH* was as follows: Chronic valv Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A Kleasonsby M.D.

7/2. 1930 (Address) 602 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cemetery A.A.Co. Date of Burial 7/6 1930

20 UNDERTAKER: Walter B. Spriggs ADDRESS 1911 W Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

Rizzo

E 58561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58561

REGISTERED NO. 13-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3708 Chestnut Ave ST., WARD)

2-FULL NAME Cecilia Rizzo

(a) RESIDENCE NO. 3708 Chestnut Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced; (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonio Rizzo

6 DATE OF BIRTH (month, day, and year) April 1, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Vito Consumo

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Rosa Marinaro

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Antonio Rizzo

(Address) 3708 Chestnut Ave

15 Filed JUL 8 1930 H. O. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1930, to July 5, 1930, that I last saw her alive on July 5, 1930, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) J. N. Wilson M. D.

, 19 (Address) 848 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL July 7 1930

ADDRESS 3605 Chestnut Ave

20 UNDERTAKER Thenwood Son.

Spec.—1-12-23—M&T—500 Bks.

E 58562

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58562

REGISTERED NO. 101-801

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 Russell ST. 24-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Mae Boyd

(a) RESIDENCE NO. 908 Russell ST., 24 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 20 1918

7 AGE: Years 12 | Months 3 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Richard Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Marie Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Marie Bailey Boyd 908 Russell St

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/2/ 1930

17 I HEREBY CERTIFY, That I attended deceased from 6/29/ 1930, to 7/2/ 1930, that I last saw her alive on 7/2/ 1930, and that death occurred, on the date stated above, at 3.20 p. m.

The CAUSE OF DEATH* was as follows: Pulmonary Hypostatic Cardiac & Respiratory failure

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Visual

(Signed) J. Wirt Bailey, M. D.

, 19 (Address) 908 Shard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: July 6, 1930

20 UNDERTAKER: Mrs Katie R. Williams

ADDRESS 3224 Schroeder St

TION is very important See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58563

CERTIFICATE OF DEATH

129 E 58563

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4218 Springwood Ave. WARD 43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Edelman

(a) RESIDENCE NO. 4218 Springwood Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John Charles Edelman

6 DATE OF BIRTH (month, day, and year) May-11-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer). house work.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Theodor Vritsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Katherine Cook.

(Address) 4218 Springwood Ave

15 Filed 6-7 1930 HAROLD R. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 / 30

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1930, to July 5, 1930, that I last saw h.. alive on July 4, 1930, and that death occurred, on the date stated above, at 6-30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

Duration Int. Nephritis Cardiac Dilation yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alson R Lemon, M. D.

7/5, 1930 (Address) 1871 Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL July 7 1930

20 UNDERTAKER Stephen Jones Son

ADDRESS 424 N. Broadway

Spec.—1-30—M. & T.—250 Bks

58569

E 58564 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58564

X 117

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St. 4-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W Hunday

(a) RESIDENCE NO. 41 Jones Ave - Catonsville ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Cl	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Jennie Hunday

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hunmsk.

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co.

PARENTS

10 NAME OF FATHER Wachel Harriday

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Catherine Hunsen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Asst Records

(Address)

15 Filed 7-1930 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from 6/27, 1930, to 7/6, 1930, that I last saw h in alive on 7/6, 1930, and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

Intestinal obstruction

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/27/30

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) B L Sams, M. D.

7/6, 1930 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Gilboa Cem DATE OF BURIAL July 8 1930

20 UNDERTAKER Easton Sons & Ellis ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 58565

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3304 Elmley Ave. (S. or W'D) 8-4A

2-FULL NAME Marie Eleder

(a) RESIDENCE NO. 3304 Elmley Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late James J. Eleder

6 DATE OF BIRTH (month, day, and year) May 5, 1871.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Austria

PARENTS

10 NAME OF FATHER Karl Kudrna

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Austria

14 Informant Dr. Franklin C. Eleder,
(Address) 3326 Richmond Ave.

15 Filed 7-7 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-4-30

17 I HEREBY CERTIFY, That I attended deceased from June, 1922 to July 4, 1930, that I last saw her alive on July 4, 1930, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

— Cerebral Apoplexy —

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Louis Praus, M. D.

19 (Address) Medical Art Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem.

DATE OF BURIAL 7/7/30

UNDERTAKER Harry A. Mitzke.

ADDRESS 4101 Edmondson Ave.

Spec.—1-12-23—M&T—500 Blks.

Vivian Grace Evans

E 58566

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58566

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cherry Hill Westport St. 25-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vivian Irene Evans

(a) RESIDENCE NO. Cherry Hill. Westport ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) ~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) Nov. 19. 1929

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
—	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. Md.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER Mildred Evans

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Henry P. Evans
(Address) Cherry Hill Westport. Md.

Filed JUL 7 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1930

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1930, to July 4, 1930, that I last saw h alive on July 4, 1930 and that death occurred, on the date stated above, at 6 p. m

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos 12 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? physical examination

(Signed) L. A. Brito M. D.

7/6 1930 Address) Pasadena, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL July 7th 1930

20 UNDERTAKER B. Schloman & Son

ADDRESS 1039 Fremont Ave

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 58567 HEALTH DEPARTMENT—CITY OF BALTIMORE 3/✓ E 58567

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1807 Guilford Ave. ST. 17-50 (WARD)

2-FULL NAME Cornelia D. Deal

(a) RESIDENCE NO. 1807 Guilford Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 23rd. 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Public School 68

(c) Name of employer City.

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Wm. C. Deal

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Balto.

12 MAIDEN NAME OF MOTHER Eliza J. Duncan

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Balto.

14 Informant Louis Deal
(Address) 3549 Greenmount Av

15 - 1930 C. HARRISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1930, to July 3, 1930, that I last saw her alive on July 3, 1930, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ....yrs. 4 mos ....ds.

CONTRIBUTORY (Secondary) -

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? yes - Microscopic

(Signed) Ronald D. Abercrombie, M. D.

7/7, 1930 (Address) 18 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. (Cremation) DATE OF BURIAL 7/7/1930

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 58568

E 58568

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3108 Monument ST., 7-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph H Hurtt

(a) RESIDENCE NO. 3108 E Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Widower

3a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Martha Hurtt

6 DATE OF BIRTH (month, day, and year) Jan 11 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or estsblishment in which employed (or employer) Store Keeper 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Hurtt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Josephine Schooler

(Address) 3108 Monument

15 Filed 7-1930 C. HAMPSON JONES, M. Registrar

by K/K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1930

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to July 4, 1930

that I last saw h~~im~~ alive on July 2, 1930

and that death occurred, on the date stated above, at 2 30 P m E.S.T

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

+ Peritonitis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Groll, M. D.

7/6, 1930 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL July 6 1930

20 UNDERTAKER Wm. E. Miller & Son

ADDRESS 2334 E Fayette St.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58569 ✓ 91-00 E 58569

E 58569

CERTIFICATE OF DEATH

REGISTERED NO. 24-35

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1455 Stenenson ST., (WARD)

2—FULL NAME Anna Biniak

(a) RESIDENCE NO. 1463 Stenenson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (Write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25 1842

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER William Prunnunski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Magdalena Rudka

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Franciszka Pipska

(Address) 1463 Stenenson st

15 Filed JUL 7 - 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/4/30

17 I HEREBY CERTIFY, That I attended deceased from June 10 1930 to July 4 1930, that I last saw h alive on July 1 1930 and that death occurred, on the date stated above, at 7300 m.

The CAUSE OF DEATH* was as follows:

Insufficiency of age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A Hampson, M. D.

, 19 (Address) 1340 Eutaw.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cemetery DATE OF BURIAL July 8 1930

20 UNDERTAKER George A. Weber ADDRESS 705 E. Lanvale

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 58570 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58570

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH St Agnes Hospital REGISTERED NO. 13-57

CITY OF BALTIMORE: (No. Caton & Wilkens Avenues St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F Young

(a) RESIDENCE NO. 1010 W. 38th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret

6 DATE OF BIRTH (month, day, and year) Apr. 4-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Md

12 MAIDEN NAME OF MOTHER Jemima Standford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md

14 Informant Margaret Young (Address) 1010 W. 38th St

15 Filed 19 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-6-1930

17 I HEREBY CERTIFY, That I attended deceased from 4-28, 1930, to 7-6, 1930, that I last saw him alive on 7-6, 1930, and that death occurred, on the date stated above, at 11 37 a m. Eastern Standard

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

Metastases to lungs.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of 6-21-30

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Robert Deiver, M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cemetery	July 8 30
UNDERTAKER	ADDRESS
W S Marshall	353 E Fall Rd

CAUSE OF DEATH must be filled in plain terms, so that it may be properly CODED. ATTENTION is very important. See instructions on back of certificates.

UL 7 - 1930

Spec.—1-10-21—M&T—1500 Bks.

E 58571

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58571

48

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 Argyle St. 17-24 WARD)

2-FULL NAME Flora M. Gibson

(a) RESIDENCE NO. 1031 Argyle St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gibson

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer —

9 BIRTHPLACE (city or town) .....
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Ennis

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Betty Douglass
(Address) 1246 Eutaw St.

15 Filed JUL 7 1930. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/7 1930

17 I HEREBY CERTIFY, That I attended deceased from June 16th, 1930, to July 7th, 1930, that I last saw h[illegible] alive on July 7th, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Multiple Causes — See Autopsy

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed) H. Lee Ellis M. D.

7/7, 1930 (Address) 524 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL July 8, 1930

UNDERTAKER John H. Troderman — ADDRESS 1027 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58572

CERTIFICATE OF DEATH.

45 E 58572

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1800 N. Washington ST. 8-16 WARD)

2-FULL NAME Laurence A. Wagner

(a) RESIDENCE. NO. 1800 N. Washington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Kellner

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Copper Works

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Frederick Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kat Knowd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Anna Wagner 1800 N. Washington St.

15 Filed ..... 19 ..... HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1930

17 I HEREBY CERTIFY, That I attended deceased from December 1929 to July 3 1930, that I last saw h[illegible] alive on July 3 1930, and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(duration) 9 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Chr. Brights Disease.

(duration) 7 yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 29, 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry E. Wilson M. D.

19 (Address) 3 W. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: 7/7 1930

20 UNDERTAKER: E. D. Fanning & Son

ADDRESS: 1938 Lafayette Ave.

CAUSE OF DEATH must be stated plainly. Use no abbreviations. TION is very important. See instructions on back of certificates.

7-1930

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

58573 — 74 — 58573

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS (WARD) 670

CITY OF BALTIMORE: (NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Hendryshot.

(a) RESIDENCE NO. 20 N. Chestey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Hendryshot.

6 DATE OF BIRTH (month, day, and year) July 17, 1887.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42	43	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Wm Harris.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosella Parks.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Record of BALTIMORE CITY HOSPITALS

(Address BALTIMORE CITY HOSPITALS, M. D.

15 Filed 7-7-1930 No. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1930, to July 5, 1930, that I last saw h[illegible] alive on July 5, 1930, and that death occurred, on the date stated above, at 8:40 A.m.

The CAUSE OF DEATH* was as follows:

Hemorrhages into cerebrum (multiple)

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam.

(Signed) Paul Padgett, M. D.

7-5, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westorne Md

DATE OF BURIAL July 7, 1930

20 UNDERTAKER John Ullrich

ADDRESS 208 Orleans

FRONT (For Instructions, See Reverse Side)

1 - 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58574

CERTIFICATE OF DEATH

47 ✓ E 58574

REGISTERED NO. 27447

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3107 Beverly Road ST.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eliza Virginia Williams (Jennie)

(a) RESIDENCE NO. 3107 Beverly Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Albert D. Williams

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Hopper

11 BIRTHPLACE OF FATHER (city or town) Upper Marlboro

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucretia Aler

13 BIRTHPLACE OF MOTHER (city or town) Reisterstown

(State or country) Maryland

14 Informant Miss Aldyth Allen

(Address) 221 West Monument Street

Filed 7-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July, 3rd. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to July 3, 1930,

that I last saw her alive on July 2, 1930,

and that death occurred, on the date stated above, at 1.45 PM

The CAUSE OF DEATH* was as follows:

Carcinoma of breast and liver

breast (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ------

Did an operation precede death? Yes Date of May 12, 1927

Was there an autopsy? No

What test confirmed diagnosis? Of breast - operation

(Signed) [signature], M. D.

7/4, 1930 (Address) 720 West North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL July, 7 1930

20 UNDERTAKER Joseph B Cook ADDRESS 1003 W Balto St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 58575

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

48v E 58575

REGISTERED NO. 27-36

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4504 Reisterstown Road St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Jones

(a) RESIDENCE NO. 4504 Reisterstown Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry W. Jones

6 DATE OF BIRTH (month, day, and year) Jan. 23, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 0-37

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER James McKenny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Maria Fardwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. August Lorenz

(Address) 4504 Reisterstown Road

15 Filed JUL 7 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 5, 1930, that I last saw her alive on July 4, 1930, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Epithelioma of nose.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral regurgitation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Sprecher, M. D.

7/7/30 (Address) 910 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL July 7 1930.

ADDRESS 915 Light St

20 UNDERTAKER Edward J. Dempsey

E 58576

E-30 M 17 M 00 B—50L

E 58576

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 28

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 Llewlyn Ave ST. 816 WARD)

2-FULL NAME Myrel S. Howard

(a) RESIDENCE NO 1008 Llewelyn Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Howard

6 DATE OF BIRTH (month, day, and year) Nov 9/1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	7	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co., Md.

PARENTS

10 NAME OF FATHER Geo. W. Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Mary's Co., Md.

12 MAIDEN NAME OF MOTHER Mary Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Mary's Co., Md.

14 Informant Mrs Anna Howard

(Address) 1008 Llewlyn Avenue

15 Filed 7-1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] Coroner, M. D.

7/7/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL 7/7 1930

20 UNDERTAKER Mrs Mary J Ruth ADDRESS 1736 Hanford Ave

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 58577 HEALTH DEPARTMENT—CITY OF BALTIMORE 185 E 58577

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Union Mem. Hosp. ST. 14-20 WARD)

2-FULL NAME Miss Mary E. Mackall

(a) RESIDENCE No. St Thomas Lane. Owings Mills ST., Md. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 21, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	4	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS
10 NAME OF FATHER Wm. Mackall
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.
12 MAIDEN NAME OF MOTHER Mary Kent
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Pt. Deceased.
(Address)

15 Filed ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1930, to July 7, 1930, that I last saw h.. alive on July 6, 1930, and that death occurred, on the date stated above, at 5:50 a.m.

The CAUSE OF DEATH* was as follows: E.S.T.

Fracture, supracondyloid, femur, left Accidental fall
(duration) ....yrs. ....mos. ....da.
CONTRIBUTORY (Secondary) Surgical Shock
(duration) ....yrs. ....mos. 1 da.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? X-Ray.
(Signed) Samuel McLean Lam M. D.
July 7, 1930 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Davidsonville Md.
DATE OF BURIAL July 7 1930
20 UNDERTAKER Jas S. Taylor Sons
ADDRESS Annapolis Md.

CAUSE OF DEATH. This information is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58578

CERTIFICATE OF DEATH

101-01 E 58578

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto. City Hospital St. 70-64 Ward)

2-FULL NAME Elmer F. Stauch

(a) RESIDENCE NO. 2432 W Franklin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 0 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Stauch

6 DATE OF BIRTH (month, day, and year) June 15 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	36	—	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) unknown
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Geo F. Stauch

11 BIRTHPLACE OF FATHER (city or town) Balto City
(State or country)

12 MAIDEN NAME OF MOTHER Martha M. Pumphrey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Washington D C

14 Informant Martha M Stauch
(Address) 2432 W Franklin

15 Filed JUL 7 - 1930 19.. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came (o... his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 2432 W Franklin

Did an operation precede death? No Date of

Was there an autopsy? Yes What test confirmed diagnosis? Clinical Lab

(Signed) James M Fenton, M. D.

7. 6 1930 (Address) 700 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 7-11 1930

20 UNDERTAKER Wm Chas E Rohde — ADDRESS 2327 Edmondson Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58579

CERTIFICATE OF DEATH

74-09 L 58579

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1018 N Carlton 16-23 Ward)

2-FULL NAME Nellie Butler

(a) RESIDENCE NO. 1018 N. Carlton. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Fm	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilson Butler

6 DATE OF BIRTH (month, day, and year) Dec 25-1863

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	66	6	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) 31
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Alex Brown

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Interment Mary Carrington
(Address) Md C Church

15 Filed JUL 7 1930 C. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... Suddn

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL July 7 1930

20 UNDERTAKER Virginia C. Brooks

ADDRESS 1463 N Ca

Section should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UL

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58580 — 1930 E 58580

CERTIFICATE OF DEATH.

Registered No. C.....

E 58580

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Henry Joyce

(Residence in Baltimore: No. 940 Burgundy St., St.; yrs. 69 mos. 7 ds. 8)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Married

6-DATE OF BIRTH. November 25th 1860 (Month) (Day) (Year)

7-AGE. 69 yrs. 7 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Paperhanger
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. John Joyce

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Harriet ?

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Edgar Joyce

(Address) 2331 W. Baltimore St.,

15- C. HANSON JONES, M. D.

Filed ....., 19.... Registrar.

JUL 7 - 1930

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 3rd 1930 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture base of skull.
Homicide. Thrown down stairs
at his home.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Eugene Feller M. D. (Coroner)

7/7/ 1930 (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery DATE OF BURIAL. July 7 1930

20-UNDERTAKER. J. J. Linker & Sons ADDRESS N & Pa Aves

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of occupation is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 58581

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58581

CERTIFICATE OF DEATH

REGISTERED NO. 188-103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST. 10-E WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thelma Mary Williams

(a) RESIDENCE NO 1226 N. Eden St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred City yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7-1-28

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

10 NAME OF FATHER Agley Williams

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Pattie Holden

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Agley Williams

(Address) 1226 N. Eden St.

15 Filed 7-7 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Auto in which she was a rider overturned when in collision with another auto

(A) (duration) 7 yrs. mos. ds. C. C Fract Skull

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Rutland & Madison

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Frauenthal, M. D. Coroner

7/7 1930 (Address) 2939 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary

DATE OF BURIAL July 7 1930

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 725 Ashland Ave

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 58582

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58582

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Scott ST. 21-24 WARD)

2-FULL NAME Joseph A. McCann

(a) RESIDENCE NO. 1209 Scott ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced

HUSBAND of (WIFE of): Mary A McCann

6 DATE OF BIRTH (month, day and year): 1868

7 AGE: Years 62; Months —; Days —; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick McCann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Kane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mary A McCann 1209 Scott St

7-5-1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 4 1930

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1930, to July 4, 1930, that I last saw h— alive on July 4, 1930, and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. A Thomas, M. D.

7/5, 1930 (Address) 1901 Griffiss

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary

DATE OF BURIAL: July 8 1930

UNDERTAKER: Edward Lowen

ADDRESS: 2337 Eutaw Pl

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—8-16-29—L. F. S.—100 Bks.

E 58583

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 58583

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 N. Eden ST 5-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Jones

(a) RESIDENCE NO. 603 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Jones

6 DATE OF BIRTH (month, day, and year) Jan-20-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. W. Jones

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary L. Harmon

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Alberta Glascoe

(Address) 603 N. Eden St.

15 Filed 7-7-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6-1930

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 5, 1930, that I last saw h[illegible] alive on July 5, 1930 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) yrs. mos. 10 da.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) C. H. Hamilton, M. D.

7/6, 1930 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery DATE OF BURIAL July 9 1930

20 UNDERTAKER Chas. H. Johnson ADDRESS 611 N. Carolina St.

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58584

CERTIFICATE OF DEATH.

129 E 58584

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 Hawthorn Road ST. 27-53 WARD)

2-FULL NAME Agnes Shipley

(a) RESIDENCE NO. 202 Hawthorne Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 6 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7. 1870

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	59	6 7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Columbus Shipley

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Elizabth White

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Miss Gertrude Shipley
(Address) 202 Hawthorne Road

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6.1930

17 I HEREBY CERTIFY, That I attended deceased from July 4 —, 1930, to July 6, 1930

that I last saw h[illegible] alive on July 6, 1930

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) — yrs. — mos 3 da.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) Unknown

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jefferson Brent M. D.

7/7 1930 (Address) 2841 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL July 8, 1930

UNDERTAKER John O. Mitchell & Sons

ADDRESS 1900 Eutaw Place

HARRISON JONES, M. D.
Registrar

John O. Mitchell

Spec.—1-30—M. & T.—250 Bks

E 58585

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

116-002 E 58585

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hospital ST., 13-52 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan A Athey.

(a) RESIDENCE NO. 3743 Beech Ave ST., Balto Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18 1870

7 AGE — Years: 59 — Months: 9 — Days: 19 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Companion

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Wm W. Athey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Isabella Hunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Hospital Records
(Address)

15 Filed JUL 7 1930 Registrar C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7/30.

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1930, to July 7, 1930, that I last saw her alive on July 7, 1930, and that death occurred, on the date stated above, at 1 p m. (standard time)

The CAUSE OF DEATH* was as follows:

Hemicolitis

(duration) yrs. mos 13 da.

CONTRIBUTORY (Secondary) Post operative obstruction (intestinal)

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/30/30 & 7/4/30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Francis W Tilsch, M. D.

July 7, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leesburg Va — DATE OF BURIAL: July 9 1930

20 UNDERTAKER: John Otterbach & Son — ADDRESS: 19 N. Eutaw Ave

Spec.—1-30—M. & T.—250 Bks.

E 58586

HEALTH DEPARTMENT—CITY OF BALTIMORE

43 E 58586

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 76-27 ST., WARD

2-FULL NAME Samuel Scott

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Odd)

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown.

9 BIRTHPLACE (city or town) Unknown

(State or country) Va.

PARENTS

10 NAME OF FATHER Samuel Scott

11 BIRTHPLACE OF FATHER (city or town) Unknown.

(State or country) Va

12 MAIDEN NAME OF MOTHER Louisa Scott

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country) Va

14 Informant Father Eustena

(Address) 1734 Division Ave

15 Filed JUL 7 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-3-30

17 I HEREBY CERTIFY, That I attended deceased from 11-14-, 1929, to 7-3-, 1930, that I last saw him alive on 7-3-, 1930, and that death occurred, on the date stated above, at 8 30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Month.

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ___ yrs. ___ mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Unk Date of ___

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fred M. Duckwall, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn City

DATE OF BURIAL 7-7 1930

UNDERTAKER George T. G. Gibson

ADDRESS 1755 Druid Hill Ave

TION is very important. See instructions on back of Certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58587 ✓ E 58587

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 S. Bradford ST., 1-3 WARD)

2-FULL NAME Frank Kruszewski

(a) RESIDENCE NO. 611 S. Bradford St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Josephine Kruszewska

6 DATE OF BIRTH (month, day, and year) Dec. 20 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Teofil Krusaewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Lipinczak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Josephine Kruszewska
(Address) 611 S. Bradford St.

15 Filed JUL 7 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to July 5, 1930, that I last saw h[illegible] alive on July 5, 1930 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis 6

(duration) ... yr. 6 mos ... ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. R. Davis M. D.
(Address) 601 N Edwood St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Judy

DATE OF BURIAL 7 1930

ADDRESS

20 UNDERTAKER John M. Weber 151 N. Chester St.

Spec.—1-30—M. & T.—250 Bks.

E 58588 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 58588

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto. City Hosp. 6-11
CITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

2-FULL NAME Carrie Osewold

(a) RESIDENCE No. 3000 E. Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	69	Unk		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 070
(b) General nature of industry, business, or establishment in which employed (or employer) Unk
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS
10 NAME OF FATHER Joshua Rawlings
11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Md.
12 MAIDEN NAME OF MOTHER Margaret Simms
13 BIRTHPLACE OF MOTHER (city or town) Unk
(State or country) Md

14 Informant Mrs. Reynolds
(Address) Baltimore City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-6-30

17 I HEREBY CERTIFY, That I attended deceased from 5-15-, 1930, to 7-6, 1930, that I last saw h[illegible] alive on 7-6-, 1930, and that death occurred, on the date stated above, at 6 10 A.m.

The CAUSE OF DEATH* was as follows:
Carcinoma of bladder with local metastasis
(duration) unk yrs. ... mos ... da.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) — yrs. — mos. 5 — ds.

18 Where was disease contracted if not at place of death? unk.
Did an operation precede death? no Date of —.
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Fred M. Dunbarell, M. D.
, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem
DATE OF BURIAL 7/8 1930
20 UNDERTAKER J. J. Moran
ADDRESS E Balto.

FROM PUBLIC HEALTH JOURNAL
JUL 7 1930 HARRISON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58589

101-001

58589

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1045 W. Barre St 21-29 Ward)

2-FULL NAME William Wallace Wheeler

(a) RESIDENCE NO. 1045 W. Barre St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Wheeler

6 DATE OF BIRTH (month, day, and year) Feb. 14-1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41	5	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John S. Wheeler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Jennie Flynn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant John A. Wheeler
(Address) 1045 W. Barre St

15 Filed 7-1930 C. HAWSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

7/6, 1930, (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	7/8 1930
20 UNDERTAKER J. J. Moran	ADDRESS 3000 E. Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58590

CERTIFICATE OF DEATH

X 182

E 58590

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Removed Died at

City of Baltimore: (No. Balt City Hospital St., 9-46 Ward)

2-FULL NAME Raymond H. Cochran

(a) RESIDENCE NO. 2728 Alameda Ave Ward Ohio

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Bernice Cochran

6 DATE OF BIRTH (month, day, and year) Dec 12 1898

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	31	7	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Inspector 086
(b) General nature of industry, business, or establishment in which employed (or employer) Insurance Co
(c) Name of employer

9 BIRTHPLACE (City or town) Brown
(State or country) Ohio

PARENTS

10 NAME OF FATHER Harry Cochran

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Brown Co Ohio

12 MAIDEN NAME OF MOTHER Beth West Adams Co Ohio

13 BIRTHPLACE OF MOTHER (city or town) Adams
(State or country) Co Ohio

14 Informant Mrs Winfred Ballard
(Address) 2728 Alameda Blvd

15 Filed 7-7 1930 19 C. HAMILTON JONES, Registrar
By Ellis, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) While bathing in Middle River (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What (est confirmed diagnosis? Clinical

(Signed) James M Fenton M. D.

19 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hamilton Ohio — DATE OF BURIAL 7/7 1930

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 58591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

52 E 58591

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 S Clinton ST. 16-7 WARD)

2-FULL NAME Ella May Schmidtmann

(a) RESIDENCE NO. 324 S Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~WIFE~~ of Jacob Schmidtmann

6 DATE OF BIRTH (month, day, and year) Sept 3 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co

PARENTS

10 NAME OF FATHER John Frite

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co

12 MAIDEN NAME OF MOTHER Ellen Ecker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co

14 Informant Jacob Schmidtmann (Address) 324 S. Clinton St

15 Filed 7-1-1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6-30

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1930, to July 6, 1930, that I last saw her alive on July 6, 1930, and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arthritis & Neuritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Jos. Chute, M. D.

7/7, 1930 (Address) 3532 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Meadow Branch

DATE OF BURIAL 7/8 1930

UNDERTAKER Mclain Cook

ADDRESS 1217 St Paul

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58592 — 34-001 ✓ — E 58592

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 647 N. Paca St. (Ward) 17-25

2-FULL NAME Emeline Frances Spratt.

(a) RESIDENCE No. 647 N. Paca St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Henry.

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	65+			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Dress Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Mass. 69

9 BIRTHPLACE (city or town) (State or country): Fra Warren. Mass

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Jeffers

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mabel Knox
(Address) 647 N. Paca

15 Filed JUL 7 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) Few hours

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 647 N. Paca

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) H. Bascom, M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Boston Mass.	7/7 1930
20 UNDERTAKER Samuel I. Newsley	ADDRESS 578 N. Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58593 — 162 — E 58593

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 17-21 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby James

(a) RESIDENCE NO. 621 Greenmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1930	July	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Jerris James

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Margrett Jennings

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant

(Address)

15 Filed 7-7 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-3-30

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

. 19 (Address) 1021 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19 JULY 7 1930

20 UNDERTAKER Commissioner Health.

ADDRESS

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 58594

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B. 2-W ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD)

2-FULL NAME Eric Edberg

(a) RESIDENCE NO. 2005 E. Pratt st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 28, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rigger

(b) General nature of industry, business, or establishment in which employed (or employer) Ship

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Edgar Edberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Anna ?Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Hospital Records (Address)

15 Filed JUL 7 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1930, to July 1, 1930, that I last saw him alive on July 1, 1930, and that death occurred, on the date stated above, at 8.10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

7-1, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] HOSPITAL

DATE OF BURIAL JUL 7 - 1930

UNDERTAKER

ADDRESS

Deputy Health Commissioner

Spec.—1-30—M. & T.—250 Bks

E 58595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 58595

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 17-24 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Banks

(a) RESIDENCE NO. 815 Pennsylvania Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha

6 DATE OF BIRTH (month, day, and year) March 4, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37 38	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber 004

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER John Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Susan Borman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed 7-3-1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-1-30

17 I HEREBY CERTIFY, That I attended deceased from 6-26-30, 19..., to 7-1-30, 19..., that I last saw him alive on 7-1-30, 19..., and that death occurred, on the date stated above, at 6:05 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. Lab.

(Signed) Paul Podgal. M. D.

7-3-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] HOSPITAL

DATE OF BURIAL JUL 7 - 1930

20 UNDERTAKER

ADDRESS

Commissioner of Health.

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58596 — 90 — E 58596

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 16-21 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Alek Smith

(a) RESIDENCE NO. ? ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): N O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Joseph Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records of (Address) Balts. City Hospitals

Filed 7-7-1930 — HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-1-30

17 I HEREBY CERTIFY, That I attended deceased from 12-24-23, 19..., to 7-1-30, 19..., that I last saw him alive on 7-1-30, 19..., and that death occurred, on the date stated above, at 7:00 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic + acute

(duration) 7 yrs. mos da.

CONTRIBUTORY (Secondary) Arteriosclerosis + Hypertension (duration) Unknown yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Paul Padget, M. D.

7-3, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JUL 7 - 1930 19

ADDRESS

20 UNDERTAKER: Commissioner Health.

U

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 58597

CERTIFICATE OF DEATH.

161-001 E 58597

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W. B. G. Hosp. ST., 16-68 WARD)

2 FULL NAME Baby Boy Poggi-

(a) RESIDENCE NO. Whitehall Md. / Baltimore, ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-28-30

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Mario Poggi

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country)

12 MAIDEN NAME OF MOTHER Wanda Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country)

14 Informant .....
(Address)

15 Filed ..... 19 ..... S. HANSON JONES, M. D. Registrar

JUL 7 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30-1930

17 I HEREBY CERTIFY, That I attended deceased from 6-28-, 19 30. to 6-30-, 19 30

that I last saw him alive on 6-30-, 19 30

and that death occurred, on the date stated above, at 4-p.m.

The CAUSE OF DEATH* was as follows:

Prematurity - baby was only of 24 weeks development.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. V. Castagna, M. D.

6/30, 1930 (Address) W. Balt. Gen.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL .....

DATE OF BURIAL 19

20 UNDERTAKER .....

ADDRESS .....

JUL 3 - 1930

TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58598 ✓ 179-001 E 58598

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 58598

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq Hosp ST. W-69 WARD)

2-FULL NAME Catherine E Meushaw

(a) RESIDENCE NO 2131 Christian ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ✓ mos. ✓ ds. How long in U. S., If of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 18, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	10	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Maitland E Meushaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jesse B. Weedon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Jesse E Meushaw

(Address) 2131 Christian St

15 Filed 7-1930 192 C. HAMPSON JONES, M. D. Registrar

RPK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ✓ death on the day stated above.

The CAUSE OF DEATH* was as follows:
Burned - Accidental - Clothes caught fire from fireworks on July 5th

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas J Brosche, M. D. Coroner

7/7 1930 (Address) 3601 Third St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL July-8 1930

UNDERTAKER Charles J. Schwab

ADDRESS 565 N. Monroe St.

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Thomas Vanskiver

E 58599

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 ✓ E 58599

2251 Sidney Ave

CERTIFICATE OF DEATH

2251 Sidney ave

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2251 Sidney ave ST., (or) WARD)

REGISTERED NO. 2537

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Vanskiver

(a) RESIDENCE NO. 2251 Sidney Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elsie Vanskiver

6 DATE OF BIRTH (month, day, and year): Oct. 18, 1893

7 AGE: Years 36 | Months 8 | Days 18 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Automobile Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: James Golden

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Robert Vanskiver

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Alberta Hissey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Robert Vanskiver

(Address): 2251 Sidney Ave Baltimore

15 Filed JUL 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6/30

17 I HEREBY CERTIFY That I attended deceased from June 1 1930 to July 6, 1930

that I last saw h... alive on July 6, 1930

and that death occurred, on the date stated above, at 8.15 a.m.

The CAUSE OF DEATH* was as follows:

Coronary occlusion

acute Alcoholism

(duration) 2 yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Raymond Stevens M. D.

July 6. 1930 (Address) 2755 Baltimore Hwy

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: July 9 1930

20 UNDERTAKER: Bernard A Funk

ADDRESS: 184 W Washington Blvd

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 58600

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 100-001

REGISTERED NO. E 58600

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3402 Fairview Ave S. WARD) 13-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret E. Parker

(a) RESIDENCE NO. 1419 University Ave N. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas E. Parker

6 DATE OF BIRTH (month, day, and year) June 20 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	51	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Peter E. Kelly

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Katherine O'Dea

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Thomas E. Parker

(Address) New York

15 Filed July 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1 1930, to July 5 1930, that I last saw her alive on July 5 1930, and that death occurred, on the date stated above, at 2 30 P E.S.T. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis c.c. myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

July, 1930 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL July 8 1930

20 UNDERTAKER Milton E. Gosson

ADDRESS 8410 W 37th

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58601 ✓ 93 E 58601

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 12 + 49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry K. Madden

(a) RESIDENCE NO. Non-resident ST., WARD Laurel Park, Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ ~~Mary~~ H. Madden

Myrtle Retowski Madden

6 DATE OF BIRTH (month, day, and year) Sept-6-1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sign Writer 059

(b) General nature of industry, business, or establishment in which employed (or employer) Plumbing

(c) Name of employer H. E. Cook & Co.

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER Joseph Madden

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Augusta Crook

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Wife Mrs. Myrtle P. Madden Laurel Park Md

(Address)

15 Filed JUL 7 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7/30.

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1930, to July 7, 1930, that I last saw h[illegible] alive on July 7, 1930, and that death occurred, on the date stated above, at 1.20 a.m.

The CAUSE OF DEATH* was as follows: Dr. Douglas Towing

Osteosarcoma

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Laurel Park, Md.

Did an operation precede death? No Date of

Was there an autopsy? Yes Partial

What test confirmed diagnosis? Autopsy

(Signed) Francis W. Gluck M. D.

July 7 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL July-9 1930

20 UNDERTAKER Stewart & Mowen Company ADDRESS 108 W. Monument

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 58602

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 58602

REGISTERED NO. 19-28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 341 S. Gilmor St. (St.) (Ward)

2-FULL NAME Mary C. Hayes,

(a) RESIDENCE NO. 341 S. Gilmor St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Columbus H. Hayes

6 DATE OF BIRTH (month, day, and year) Oct. 19, 1855.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
74	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John R. Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs. Florence Dittelmar, 341 S. Gilmor St.

15 Filed JULY 7 1930 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-5-30

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1930, to July 5, 1930, that I last saw her alive on July 4, 1930, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

Carcinoma hyperinoplasia

Emphysema chronic

Probable (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Arterial sclerosis (duration) yrs. mos. 1/2 hours.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Harry [illegible] M. D.

7/7, 1930 (Address) 11 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 7/8/30 19

UNDERTAKER Harry A. Mitzel, 41

ADDRESS 16 Edmondson Ave.

TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

E 58603

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

166 ✓ E 58603

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 3-4 WARD)

2-FULL NAME Marian Bugno

(a) RESIDENCE No 1006 Gough St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28/1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailoring
(b) General nature of industry, business, or establishment in which employed (or employer) Helper
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Stanley Bugno

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Dudaryk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mother
(Address) 1006 Gough St

15 Filed JUL 8 - 1930 by C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury Poisoning

Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) [signature] Coroner, M. D.

7/7/30 (Address) 598 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stanislaus July

DATE OF BURIAL 8 1930

20 UNDERTAKER F W Ozarzewski 1930

ADDRESS 1930 Eastern ave

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

Dr Messick 1700 Linden Ave

E 58604 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58604

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5320 Catalpa Rd (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Andersen

(a) RESIDENCE NO. 5320 Catalpa Rd ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Anna Andersen

6 DATE OF BIRTH (month, day, and year) 3/21/1866

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Building

(c) Name of employer Mr Benson

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER Lorenz Andersen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant Mrs Anna Andersen

(Address) 5320 Catalpa Rd

15 Filed ....., 19.... C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/5/30

17 I HEREBY CERTIFY, That I attended deceased from June 8th, 1929, to July 5th, 1930, that I last saw him alive on July 3th, 1930, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Abdominal Wall

What test confirmed diagnosis? Gross Examination

(Signed) William Messick M. D.

, 19 (Address) 1700 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL 7/8/1930

20 UNDERTAKER Wm Cook 1217

ADDRESS St Paul

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58605

CERTIFICATE OF DEATH

90 VE 58605

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1227 N. Charles St. St. 11-15 Ward)

2-FULL NAME Minnie A. Gross.

(a) RESIDENCE NO. 1227 N. Charles St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 10 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) August 10, 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	48	10	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Nurse.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Herman Gross.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Agnes Caunisius.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Cecil Co. Md.

14 Informant Casper A. Gross. (brother)
(Address) 2502 Guilford Ave.

15 Filed JUL 8 - 1930 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Acute dilatation of the Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

7/7, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	7/9 1930
20 UNDERTAKER William Cook	ADDRESS 1275 Law

IMPORTANT—Physician or Coroner must fill out this certificate in duplicate. Please write plainly and in ink. Answer every question. Do not abbreviate. Be sure to fill out the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58606

E 58606

CERTIFICATE OF DEATH.

REGISTERED NO. 23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 6506 Fait Ave ST. (WARD) 26-37

2-FULL NAME Charles Beyer

(a) RESIDENCE NO. 6506 Fait Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 26 - 1880

7 AGE: Years 49 | Months 11 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Eastern Casket Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Beyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Forst

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1 1930, to July 6th 1930, that I last saw him alive on July 6th 1930, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Encephalitis (Epidemic)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harris J. Shmidlapp, M. D.

, 19 (Address) 6018 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Cemetery

DATE OF BURIAL: July 10 1930

UNDERTAKER: George W. Zirkler

ADDRESS: 1737 E. Eager St

JUL 8 - 1930

Filed

Spec.—1-30—M. & T.—250 Bks.

E 58607 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 58607

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2007 E Lanvale ST. 8-17 WARD)

2-FULL NAME Charles G. Diedemann

(a) RESIDENCE NO. 2007 E Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie F. Diedemann

6 DATE OF BIRTH (month, day, and year) Oct 7 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	9		

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer) Auto supplies

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Diedemann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emilie Gellert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Diedemann
(Address) 2007 E Lanvale

15 Filed ..... 193.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from May, 1930, to July 2, 1930, that I last saw him alive on July 2, 1930, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Osteogenic Sarcoma on sixth Rib do not recollect
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Asthenia (duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5/27/30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. J. Furbour M. D.

7/7, 1930 (Address) 918 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL July 11, 1930

20 UNDERTAKER John Wm. Ward

ADDRESS 2408 Eutaw

Spec.—1-30—M. & T.—250 Bks.

E 58608 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58608

CERTIFICATE OF DEATH.

194

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 N Luzerne ave ST., 10 WARD)

2-FULL NAME Julia Metz Mann

(a) RESIDENCE NO. 609 N Luzerne ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Metz Mann

6 DATE OF BIRTH (month, day, and year) Oct 1 1835

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	94	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Forch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Lutz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs John Mueller

(Address) 609 N Luzerne ave

15 Filed JUL 8 - 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6-1930

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 6, 1930, that I last saw h.r alive on July 6, 1930, and that death occurred, on the date stated above, at 6.20 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Uraes.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? At place of birth

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms

(Signed) Laws V Ogle M. D.

7-1-1930 (Address) 2601 E Monument St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews Cem

DATE OF BURIAL Jul 12 1930

UNDERTAKER M. E. John Uhlrich

ADDRESS 2015 Eutaw

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58609

E 58609

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 N. Linwood Ave ST., 9-11 WARD)

2-FULL NAME Mary H. Windsor

(a) RESIDENCE NO. 525 N. Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of or) WIFE of Eldridge Windsor

6 DATE OF BIRTH (month, day, and year) Aug. 8 1842

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
87	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER Nathaniel Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER Sallie White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Thos. A. Windsor (Address) Somerset County.

15 Filed JUL 8 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1930

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to July 7, 1930, that I last saw her alive on July 7, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart Disease (Angina Pectoris)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis Vacuta

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas J Taylor, M. D.

7/8, 1930 (Address) 1190 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Deals Island Somerset Co

DATE OF BURIAL July 9th 1930

20 UNDERTAKER B. C. Forlo

ADDRESS 1500 E. Pacy St.

THIS is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 58610

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58610

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Springfield ave ST., 29-47 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael J. Geraghty

(a) RESIDENCE NO. 610 Springfield ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widower

6a If married, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mary E. Geraghty

6 DATE OF BIRTH (month, day, and year) Apr 12 1860

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Geraghty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Winifred Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Ely Moore

(Address) 610 Springfield ave

15 Filed 8 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930, to July 6, 1930

that I last saw h ~~ewive~~ on July 6, 1930

and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Toxemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of liver with

Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Bruins, M. D.

19 (Address) 4704 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL July 9, 1930

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Belvedere

Cor.—10-10-29—A Co.—100 Bks.

E 58611

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 58611

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2718 W. North Ave. St. 15-68 Ward)

2-FULL NAME Catherine Granger

(a) RESIDENCE No. 2718 W North Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of No,

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Levin Granger

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Cox

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs Tonnet D. Butler
(Address) 704 Fordham Rd

15 Filed ..... 19 ..... C. HAMPSON JONES, M. Registrar

JUL 8 1930

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) July 15 M. D.

19 (Address) 1c Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL July 18 1930

20 UNDERTAKER P. John F. Denny

ADDRESS 715 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 58612

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58612

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 13-52 Ward)

2-FULL NAME George Lee French

(a) RESIDENCE NO. 3742 Hickory Ave. St., I3 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August I6, I929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	--	I0	2I	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George E. French

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Edith E. Freeland

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Edith E. French
(Address) 3742 Hickory Ave

15 Filed 8-1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7/30 193

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Purulent Meningitis- (Unable to Classify)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam Spinal Fluid

(Signed) J. S. Kalen, M. D.

7/7/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden — DATE OF BURIAL July 8 1930

20 UNDERTAKER Horace A. Burgee — ADDRESS 363 Hall. Rd.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58613

E 58613 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Montford Ave ST. 6-10 WARD)

2-FULL NAME Victoria Riley

(a) RESIDENCE No. 207 Montford Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Riley

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Bowser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Victoria Bowser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Riley (Address) 207 Montford Ave

Filed 8 1930, 19.. C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5/30

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to July 5, 1930, that I last saw h.er alive on July 4, 1930 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) asthma (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) H. Boyer, M. D.

, 19 (Address) 1904 E. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem

DATE OF BURIAL 7-8 1930

20 UNDERTAKER Byron A Wright

ADDRESS 1248 McCulloh St

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HENSCHEL

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58614

66 E 58614

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 115 N. Gay (Hospital or Institution) St., 4th Ward)

2-FULL NAME Clemens Henschel

(a) RESIDENCE NO. 115 N. Gay St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M.	W.	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Margt. Henschel

6 DATE OF BIRTH (month, day, and year) Dec. 16 1848

7 AGE Years	Months	Days	IF LESS than 1 day, ...hrs. or ...min.
81	6	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter Builder
(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER C. Henschel

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER C. Bergman

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant C. Henschel
(Address) 119 Bloomingdale

15 Filed July 9 1930 C. EMMETT JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4/3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Senility

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. T. Peters, M. D.

1930 (Address) 639 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cem. St. Peters Cemetery	July 9th 1930
20 UNDERTAKER Lilly & Julian Funk	ADDRESS 403 S. Mosher St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58615 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58615

CERTIFICATE OF DEATH.

47

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 730 S. Eutaw ST., (or) WARD 26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Lawson

(a) RESIDENCE NO. 730 S. Eutaw ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Gustavus Lawson

6 DATE OF BIRTH (month, day, and year) Feb. 12th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Peter Lieberman

11 BIRTHPLACE OF FATHER (city or town) Balto. Md

(State or country)

12 MAIDEN NAME OF MOTHER Minnie Gumpke

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Gustavus Lawson

(Address) 730 S. Eutaw St.

15 Filed 1930 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6th/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1930, to July 6, 1930, that I last saw h[illegible] alive on July 6, 1930, and that death occurred, on the date stated above, at 7.55 p m.

The CAUSE OF DEATH* was as follows:

Cardiac Asphyxia

Cancer of Breast

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Cancer of Breast

(duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No Physical Signs

What test confirmed diagnosis?

(Signed) [illegible] M. D.

July 7 1930 (Address) 1301 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	July 9th 1930
20 UNDERTAKER Lilly & Zeiler Inc	ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 58616

E 58616

CERTIFICATE OF DEATH.

REGISTERED NO. 128

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST. 14-27 WARD)

2-FULL NAME Herbert Mackey

(a) RESIDENCE NO. 1703 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 24 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Herbert Mackey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Centreville

12 MAIDEN NAME OF MOTHER Ella Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant 1703 W Lexington St

(Address) C. HAMPSON JONES, M. D.

Filed JUL 8 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-7-30

17 I HEREBY CERTIFY, That I attended deceased from 7-5-, 1930, to 7-7, 1930, that I last saw h- alive on 7-7-, 1930, and that death occurred, on the date stated above, at 10:21 m.

The CAUSE OF DEATH* was as follows:

Acute Bacterial Endocarditis

Acute nephritis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. L. Jackson M. D.

1930 (Address) 600 N Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL July 10 1930

ADDRESS 1700 N

UNDERTAKER Emma E Wright Co

Spec.—1-30—M. & T.—250 Blks

E 58617

E 58617

E 58617

E 58617

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (NO. 12-49 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Fannie Ephraim

(a) RESIDENCE NO. Brunswick Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan Ephraim

6 DATE OF BIRTH (month, day, and year) May 18, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	2 1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joel Friedlander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie Marburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hosp. Report

(Address)

JULY 8 - 1930 Registered THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1930, to July 7, 1930, that I last saw her alive on July 7, 1930, and that death occurred, on the date stated above, at 9:35 P.M.

The CAUSE OF DEATH* was as follows:

Fever of undetermined origin following operation

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Gastric ulcer

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of July 5, 1930

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Richard I. Shackelford M. D.

July 7, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rest DATE OF BURIAL July 8 1930

20 UNDERTAKER Jack Levis 1434 Eutaw ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 58618

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 E 58618

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto. Gen Hosp ST. 700-47 WARD)

2-FULL NAME Jerome Cain

(a) RESIDENCE NO. 534 Brice ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	19 48	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Jerome Cain

11 BIRTHPLACE OF FATHER (city or town) Balto, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Laura Gutcher

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md.
(State or country)

14 Informant Jerome Cain
(Address) 534 Jr. Brice St.

15 Filed JUL 8 - 1930 C. HARRISON JONES, M.D. Registrar
For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7. 1930

17
I HEREBY CERTIFY, That I attended deceased from July 3, 1930, to July 7, 1930,
that I last saw h.l m alive on July 7, 1930
and that death occurred, on the date stated above, at 11.50 a.m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. mos 2/ ds.

CONTRIBUTORY (Secondary) Low

Toxemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) C. F. Joslin, per Friedman, M. D.

, 19 (Address) W. Balto. Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 7/9 1930

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul

CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

58619

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58619

90

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 E. Preston ST. 9-18 WARD)

2-FULL NAME Saidie Welch.

(a) RESIDENCE NO 714 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Hayne **Welch.**

6 DATE OF BIRTH (month, day, and year) May 15/1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	1	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Maude Haynie (Daughter)
(Address) 714 E. Preston St

15
Filed ..... 192 .....
JUL 8 - 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr. Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Bullen, M. D.
Coroner

7/8/30 (Address) 508 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 9 1930
20 UNDERTAKER	ADDRESS
William Cook	1217 St Paul

TION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 58620

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 58620

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 Montpelier ST. 9-46 WARD)

2-FULL NAME William H. Cooper

(a) RESIDENCE NO 1132 Montpelier ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5/1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	07	9	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. S. Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm. F. Still
1132 Montpelier St
(Address)

15 Filed 192 Registrar

JUL 8 - 1930 C. Mackey

TION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Collins, M. D.
Coroner

7/8/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery Md

DATE OF BURIAL 7/9 1930

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul

Spec.—1-30—M. & T.—250 Bks.

E 58621

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58621

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Roemer

(a) RESIDENCE NO. 1714 N. Port ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Harry Roemer

6 DATE OF BIRTH (month, day, and year) Aug 16th 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas Hickman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mollie Wright

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Harry Roemer
(Address) 1714 N Port St

Filed 8-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from 6-26-30, 19 to 7-6, 19 30

that I last saw her alive on 7-6, 19 30,

and that death occurred, on the date stated above, at 5.09 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Hypertension

unknown
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Anaemia
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory & Clinical

(Signed) Wm Kennedy, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laudon Park Cem	July 9th 1930
19 UNDERTAKER Leo D. Leook	ADDRESS 1723 Pitts Pl Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 58622

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58622

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2934 Greenmount ave ST. 12-50 WARD)

2—FULL NAME Frank A. Lyons

(a) RESIDENCE NO. 2934 Greenmount ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Shorter Lyons

6 DATE OF BIRTH (month, day, and year) Sept 4, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Buildings &c.

(c) Name of employer Business for self

9 BIRTHPLACE (city or town) (State or country) Carroll County

PARENTS

10 NAME OF FATHER D. J. Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER J. Dacey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Catherine Lyons

(Address) 2934 Greenmount Ave.

15 Filed JUL 8 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 - 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1 - 1930, to July 6 - 1930, that I last saw h... alive on July 6 - 1930 and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis - myocardial insufficiency

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) none known

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Phys. signs

(Signed) Chas J. Keller, M. D.

7/7, 1930 (Address) 222 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 7/9 1930

20 UNDERTAKER L. Vernon Lemmon

ADDRESS 4611 Park Heights Ave.

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58623

CERTIFICATE OF DEATH.

38 E 58623

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ST. 16-23 WARD)

2-FULL NAME Francis Morris

(a) RESIDENCE NO. 704 N- Carey ST., St- WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Child

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7 wks	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER Chas. Morris

11 BIRTHPLACE OF FATHER (city or town) S-Car
(State or country)

12 MAIDEN NAME OF MOTHER Gladys Stockton

13 BIRTHPLACE OF MOTHER (city or town) N. C-
(State or country)

14 Informant Friends—
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30-30

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to June 30, 1930, that I last saw him alive on June 30, 1930, and that death occurred, on the date stated above, at 11 55 a m.

The CAUSE OF DEATH* was as follows:

Syphilis, congenital -

(duration) yrs. 17 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) J W Bickford, M. D.

7/1, 1930 (Address) J Hutt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS 1930

Spec.—1-12-23—M&T—500 Blks.

E 58624 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

161-001

E 58624

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W. B. T. Hosp. ST. 16-68 WARD)

2-FULL NAME Baby Boy Andrini

(a) RESIDENCE NO. Baltimore, ST., WARD Wash D.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-1-30

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Mr Walter Martin

11 BIRTHPLACE OF FATHER (city or town) Wash. D.C.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Cullen

13 BIRTHPLACE OF MOTHER (city or town) Wash. D.C.
(State or country)

14 Informant .....
(Address) .....

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.

8-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-1-1930

17 I HEREBY CERTIFY, That I attended deceased from 7-1-, 1930 to 7-1-, 1930
that I last saw h. alive on 7-1-, 1930
and that death occurred, on the date stated above, at 3.20 m.

The CAUSE OF DEATH* was as follows:

Premature Delivery (6½ mos)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edw Wiesing, M. D.

(Address) 1000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
JOHNS HOPKINS HOSPITAL

DATE OF BURIAL [redacted]7-, 1930

20 UNDERTAKER .....

ADDRESS .....

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58625

CERTIFICATE OF DEATH.

E 58625

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2813 St Paul (St.) 17-50 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis F Sweeny

(a) RESIDENCE No. 2813 St Paul ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	73	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Sweeny

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Ellen E Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Grace Welsh Sweeny
(Address) 2813 St Paul

15 Filed ... 19... C. HARRISON JONES, M. D. Registrar
JL 8 - 1930 By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7. 7. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 7, 1930,
that I last saw him alive on July 7, 1930,
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ... yrs. ... mos 5 ds.

CONTRIBUTORY (Secondary) Pneumonia Grave

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of ...

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) James C. Clarke, M. D.

7/8/30 (Address) Catonsville apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount — DATE OF BURIAL July 9 1930

20 UNDERTAKER George J Smith — ADDRESS Hollins 53

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Mary Gorman

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

B 58626

185 E 58626

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St., 9-19 Ward)

2-FULL NAME Mary Gorman

(a) RESIDENCE NO. 1910 Bond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home work
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John McManus

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Ramsey

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Hospital Record.
(Address)

Filed JUL 8 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: (Fract. Hip + Fall in her bed room
Cardio Renal Arterio Sclerosis

Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Pneumonia Hypostatic

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. T. Parlett, M. D.

July 8 1930 (Address) 1657 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL July 10 1930

20 UNDERTAKER Mary M. Wiedefeld — ADDRESS 501 E 22nd

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 58627

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58627

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3504 Reisterstown Rd. ST. 15-54 WARD)

2-FULL NAME Elsie Steinmetz

(a) RESIDENCE. NO. 3504 Reisterstown Rd ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs — mos. — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 9/1862

7 AGE: Years 68 | Months 4 | Days 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House maid

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer: B.B. Hartz

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Herman Steinmetz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Herman Rosenthal (Address) 1945 Mulberry St

15 Filed JUL 8 - 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1929. to July 7, 1930.

that I last saw her alive on July 7, 1930

and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows: Pulmonary Edema

3 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insuff. Do not know (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) B M Bernhardt M. D.

7/8, 1930 Address) 3455 Pk Hghts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: 7/9 1930

20 UNDERTAKER: E. D. Fanning Son - 1386 Lafayette — ADDRESS

TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58628

90 E 58628

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1242 N. Broadway St. 813 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Sandrock

(a) RESIDENCE NO. 1242 N. Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Louise Sandrock

6 DATE OF BIRTH (month, day, and year) October 2, 1854

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	75	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Julius Sandrock

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia M. Kinderwatter

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country) Germany

14 Informant Louise Sandrock

(Address) 1242 N. Broadway

15 Filed JUL 8 - 1930 C. HARRISON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1936 to July 1 1930

that I last saw him alive on July 1 1930

and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Heart Disease

Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock M. D.

(Address) 3809 Fen Church Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery Date of Burial July 10 1930

20 UNDERTAKER Wm. L. Black ADDRESS 927 N. Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58629

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58629

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary A Hardesty

(a) RESIDENCE NO. Bridgeville Del. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced ~~Husband of~~ WIFE of Howard E. Hardesty

6 DATE OF BIRTH (month, day, and year) 5/16/1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Burrsville Maryland

PARENTS

10 NAME OF FATHER F. A. Potter

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Mary Thawley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant H E Hardesty (Address) Burrsville Md

15 Filed JUL 8 1930 W. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 4th, 1930 to June 8th, 1930, that I last saw h.. alive on June 8th, 1930, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver (Primary)

Peritonitis Generalized

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Procedure

(Signed) W. H. Varney, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bridgeville Del. DATE OF BURIAL July 11 1930

20 UNDERTAKER W. J. Tuckner & Sons ADDRESS North East Md

TION IS VERY IMPORTANT. SEE INSTRUCTIONS ON REVERSE SIDE

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58630

CERTIFICATE OF DEATH

129 E 58630

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 Bunneke ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George M. Stiffler

(a) RESIDENCE NO. 701 Bunneke ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Stiffler

6 DATE OF BIRTH (month, day, and year) Sept 28, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Stiffler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Bobilitta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Aubrey Stiffler (Address) 701 Bunneke St.

15 Filed 19 C. RAMSAY JONES, M. D. Registrar

9 8 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7-1930

17 I HEREBY CERTIFY, That I attended deceased from May 17- 1930, to July 7- 1930,

that I last saw h was alive on July 5- 1930

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyelitis

(duration) - yrs. 9 mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? urinalysis & Symptoms

(Signed) Chester Roland, M. D.

7-8- 1930 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Grove, Balto. County DATE OF BURIAL July 10, 1930

20 UNDERTAKER E. Leroy Stiffler, Inc ADDRESS 125 E. North ave

Cor.—10-10-29—A Co.—100 Bks.

58631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58631

REGISTERED NO. 196

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Paul & Hendenson Row 470 St., Ward)

2-FULL NAME Michael Boznango

(a) RESIDENCE NO. 1308 N. Charles St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Boznango

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
about 38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER John Boznango

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Johanna Benlett

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Mrs. Mary E. Boznango
(Address) 1308 N. Charles Street

15 Filed JUL 8 1930 H. [illegible] JONES Registrar
by [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:
Electrocution
Carcinoma Cardiac
Accidental (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) John Mossinelli, M. D.
7/7. 1930 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery — DATE OF BURIAL July 9, 1930

20 UNDERTAKER E. LeRoy Stufflebeem, Inc — ADDRESS 125 E North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 58632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 ✓ E 58632

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital 48 Ward)

2-FULL NAME Charles Yoe

(a) RESIDENCE NO. 403 Markland Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Callahan Yoe.

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
About 62 Years.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Meat Packer

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John Yoe

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Wife Catherine Yoe

(Address) 403 Markland Ave

15 Filed JUL 9 - 1930 C. HAMPSON JONES, M. D. Registrar

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/8/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

about 2 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene Foot

(duration) yrs. 1 mos. ds.

(Signed) James W Hendrix M. D. (Coroner)

7 9, 1930 (Address) 7005 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 403 Markland Ave

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Date of Burial July 9, 30

20 UNDERTAKER Edmund W. Conkling ADDRESS 948 Eager

Spec.—2-29-28—L. F. S.—500 Blks.

Tillie Kaplan

E 58633

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 N

E 58633

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 748 Penna ave. ST. 17-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Tillie Kaplan

(a) RESIDENCE NO. 748 Penna Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	widowed

3a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND of~~
(or) WIFE of Louis Kaplan

6 DATE OF BIRTH (month, day, and year) May 8-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Benjamin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hyman Kaplan
(Address) 748 Penna. ave.

15 Filed JUL 9 - 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8-1930

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1930, to July 8, 1930

that I last saw h~~e~~ alive on July 8, 1930

and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

7/8, 1930 (Address) 1663 N North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	July 9 1930
20 UNDERTAKER Jack Levy	ADDRESS 1439 S Bals

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E58634 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-66 E 58634

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 E. Hill ST. 42-33 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joan Marie Cannon

(a) RESIDENCE NO. 3 E. Hill ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Walter Cannon

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Irene Reed

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant mother
(Address)

15 Filed 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1930, to July 8, 1930, that I last saw her alive on July 8, 1930 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage
(following normal birth)
(duration) ....yrs....mos....ds.

CONTRIBUTORY ....
(Secondary)
(duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? no Date of ....

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) M. Alexander Hovey M. D.

, 19 (Address) 15-16 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem.

DATE OF BURIAL 7/9 1930

20 UNDERTAKER L. F. M. & Co.

ADDRESS 130 E. Fort.

Spec.—2-29-28—L. F. S.—500 Blks.

E 58635 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58635

8-85

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1437 William St. ST., 24 33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Roy King Gibson

(a) RESIDENCE NO. 1437 William St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 1 mos. 26 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie S. Gibson

6 DATE OF BIRTH (month, day, and year) May 12 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work B & O R. R.

(b) General nature of industry, business, or establishment in which employed (or employer) Brakeman.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co. Md.

PARENTS

10 NAME OF FATHER John Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Josephine Simpler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del.

14 Informant Mrs. Gibson

(Address) 1437 William St.

15 Filed JUL 9 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1930

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1930, to July 8, 1930, that I last saw h... alive on July 8, 1930 and that death occurred, on the date stated above, at 4. A. m.

The CAUSE OF DEATH* was as follows:

Arteria sclerosis with Hypertension

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Sidney F. Streett, M. D.

7/9, 1930 (Address) 450 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown Md.

DATE OF BURIAL 7/10 1930

UNDERTAKER I. Frew McCully

ADDRESS 130 E. Fort

Spec.—1-30—M. & T.—250 Blks

E 58636

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58636 ✓ 137

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 47 WARD)

2-FULL NAME Margaret Quirk

(a) RESIDENCE NO. Havre De Grace ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse. grad

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Brooklyn
(State or country) N. Y.

PARENTS

10 NAME OF FATHER Michael H. Quirk

11 BIRTHPLACE OF FATHER (city or town) Havre de Grace
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Sullivan

13 BIRTHPLACE OF MOTHER (city or town) Bayard Pennsylvania
(State or country) Maryland

14 Informant Mercy Hospital
(Address)

Filed 9 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1930, to July 9, 1930,
that I last saw her alive on July 9, 1930,
and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:

Renal Calculus.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Peritonitis following Nephrotomy 3 ds.
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 26

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Eldred Roberts, M. D.

7/9/30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Erin Cemetery

DATE OF BURIAL July 11 1930

20 UNDERTAKER Henry W. Meyerson

ADDRESS 805 N. Calvert St.

Spec.—8-16-29—L. F. S.—100 Bks.

E 58637

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58637

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 N Mount ST. 15-21 WARD)

2—FULL NAME Mamie E. Queen

(a) RESIDENCE NO. 1635 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life. yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	Colored	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Allen Queen

6 DATE OF BIRTH (month, day, and year) Oct 9. 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic.

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Charles H. Boyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elenora Hall

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Johnson.

(Address) 1635 N. Mount St

15 Filed JUL 9 1930 C. HAMPSON JONES, M. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1930 to July 7, 1930, that I last saw her alive on July 7 1930 and that death occurred, on the date stated above, at 8 35 A. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 5 mos. — da.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) John D. Quinn, M. D.

(Address) 1507 N. Fulton Ave

July 8. 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL July 12 1930

20 UNDERTAKER Thomas E Kelson — ADDRESS 1303 Eastern Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58638

E 58638

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 N Bond ST., 7-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Virgie Summerville

(a) RESIDENCE NO. 614 N Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Summerville

6 DATE OF BIRTH (month, day, and year) Dec 12, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
61	62	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Home work

(b) General nature of industry, business, or establishment in which employed (or employer) 670

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER John Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Clara Howard

(Address) 614 N Bond St

15 Filed ..., 19 C. HAMPSON JONES, Registrar

JUL 9 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6-1930

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1930, to July 6, 1930, that I last saw h[illegible] alive on July 6, 1930 and that death occurred, on the date stated above, at 5-45 pm.

The CAUSE OF DEATH* was as follows: E. Standard

Apoplexy

(duration) 0 yrs. 0 mos. 9 ds.

CONTRIBUTORY (Secondary) Valvular heart disease

Bright's (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Edward Fisher, M. D.

7-6, 1930 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Abingdon Md	July 9 1930
20 UNDERTAKER Wm F. G. Locks	ADDRESS 1302 Jeffers

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58639

CERTIFICATE OF DEATH

E 58639

REGISTERED NO. 15-59

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2417 N. Pulaski ST.) (WARD) Haddaway

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Dawson Haddaway

(a) RESIDENCE NO. 2417 N. Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 13 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Godwin

6 DATE OF BIRTH (month, day, and year) Nov. 14/1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	82	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cabinet Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer Talbott Co. Md.

9 BIRTHPLACE (city or town) (State or country) Talbott Co. Md.

PARENTS

10 NAME OF FATHER John Haddaway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbott Co. Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Aug. Schneider (Address) 2417 N. Pulaski St. Baltimore, Md.

15 Filed Aug 9 - 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8/30

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to July 8, 1930, that I last saw him alive on July 7, 1930 and that death occurred, on the date stated above, at 7:15 A. m.

The CAUSE OF DEATH* was as follows:

Senility, not Tertiary Malarial Fever, cause, Arterial Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Inability to take normal food & Anemia (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Talbott Co Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. A. Smith, M. D.

7/8, 1930 (Address) 1605 N. Wood Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL JUL 10 1930

20 UNDERTAKER Robert S. Sittle

ADDRESS 2700 EDMONDSON AVE.

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58640

2382 E 58640

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58640

CERTIFICATE OF DEATH.

1-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

2-FULL NAME Edward Mc Nertney

(a) RESIDENCE NO. Orduliss Home ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 18 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) May - 20 - 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
31	30	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Penn —
(State or country)

PARENTS

10 NAME OF FATHER John Mc Nertney

11 BIRTHPLACE OF FATHER (city or town) Pa —
(State or country)

12 MAIDEN NAME OF MOTHER Mary Carlos

13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)

14 Informant Friends — JOHNS HOPKINS HOSPITAL
(Address)

15 Filed 9 - 1930 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 - 30

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1930, to July 9, 1930, that I last saw h. alive on July 9, 1930, and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) ..... yrs, ... mos. 18 ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) H. Bridal Hedwig M.D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburgh Pa.

DATE OF BURIAL July 12th 1930

20 UNDERTAKER B. L. Forle

ADDRESS 1000 N. Paca St.

FOR IS very important. See instructions on back of certificate

Spec.—2-29-28—L. F. S.—500 Bks.

Warner

E 58641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161 601

E 58641

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby girl Warner

(a) RESIDENCE NO. 311 W Preaux Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9 1930.

7 AGE	Years	Months	Days	If LESS than 1 day, 7 hrs. or 7 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Douglas S. Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Parkton, Maryland

12 MAIDEN NAME OF MOTHER Margaret Catherine Smithel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Douglas S. Warner

(Address) 311 Preaux Avenue

15 Filed July 10 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to July 9, 1930

that I last saw he alive on July 9, 1930

and that death occurred, on the date stated above, at 7:22 A.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation

(Signed) Hugh Leak, M. D.

19 (Address) 16 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL July 10, 1930

20 UNDERTAKER John C Mitchell & Son

ADDRESS 1900 Eutaw Place

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 58642

E 58642 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

153

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital WARD)

2-FULL NAME Mrs. Margaret Brocato

(a) RESIDENCE NO. 3830 South 6th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Married

5a If married, widowed, or divorced HUSBAND) of or) WIFE of Natale Brocato

6 DATE OF BIRTH (month, day, and year) August 9th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Antony Bartolotta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Teresa Piccitello

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Salvatore Bartolotta

(Address)

15 Filed JUL 9 - 1930. C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-8-30

17 I HEREBY CERTIFY, That I attended deceased from 7-6, 1930, to 7-8, 1930, that I last saw her alive on 7-8, 1930, and that death occurred, on the date stated above, at 2.43 a. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cellulitis of scalp

Carbuncle (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-6-30

Was there an autopsy? no

What test confirmed diagnosis? Physical Findings

(Signed) Joseph F. Paul Carter M.D.

(Address) South Baltimore Gen'l Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL July 10th 1930

20 UNDERTAKER Frank V. Pikestone

ADDRESS 2818 E Baltimore St

IF A PHYSICIAN IS NOT IN ATTENDANCE, SEE INSTRUCTIONS ON BACK OF CERTIFICATE

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58643

CERTIFICATE OF DEATH.

117 E 58643

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto. Gen Hosp ST. 11-24 WARD)

2-FULL NAME Jean Kristen

(a) RESIDENCE NO. 1063 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret H. Kristen

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. A.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) S A

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S A

14 Informant Margaret H. Kristen (Address) 1063 McCulloh

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6/30 19

17 I HEREBY CERTIFY, That I attended deceased from 7/2/30, 19, to 7/6/30, 19, that I last saw h alive on 7/6/30, 19, and that death occurred, on the date stated above, at 5:50 p. m.

The CAUSE OF DEATH* was as follows: perforated appendicitis and general peritonitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/2/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. G. Smith Clinician per Friedman, M. D.

, 19 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 7/10 1930

20 UNDERTAKER Samuel Steinberg

ADDRESS 1178 N Bridge

HAMPSON JONES, M.

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58644

CERTIFICATE OF DEATH.

E 58644

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 429 W Biddle (St.) 11-24 (WARD)

2-FULL NAME Georgie Friend

(a) RESIDENCE NO. 429 W Biddle ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): June - 1886

7 AGE: Years 44; Months /; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid 070

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Saml. Friend

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Cornelia Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mary Fulton

(Address): 429 W. Biddle

Filed 7 1930, 19 ... C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6 1930

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1930 to July 6, 1930

that I last saw h alive on July 6, 1930

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

(Address) 1211 Mt Royal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: 7/9 1930

UNDERTAKER: Saml F Lemley

ADDRESS: 429 W Biddle

THIS IS very important. See instructions on back of certificate.

Coc.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58645

CERTIFICATE OF DEATH

REGISTERED NO. 58645

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 207 N. Hill St- St. 23-31 Ward 15

2-FULL NAME Ethel Barnes.(C)

(a) RESIDENCE NO. 207 N. Hill St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) December 15, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	0	6	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Cooper.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 ~~MAIDEN~~ NAME OF MOTHER Claudie Barnes.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Claudie Barnes.(C) mother
(Address) 207 N. Hill St.

15 Filed ....., 19.... C. THAMPSON JOHNS, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) C. M. Leonhardt, M. D.

7/9, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M. E. Zion Ct	July 9 1930
UNDERTAKER	ADDRESS
J. L. Brown & Son	108 N. Monroe

1930

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58646

CERTIFICATE OF DEATH.

X 101-08

E 58646

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 619 Hanover St.) (Ward) 7/19/30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johnnie May Bobchee ~~Johnnie May Rayner~~ D/B.

(a) RESIDENCE NO. 619 Hanover St. Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 13th 1926

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	4	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Monongah City

(State or country) Monongah

PARENTS

10 NAME OF FATHER Julius ~~Rayner~~ Bobchee

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Edna Outing

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) S. C.

14 Informant Edna Bobchee

(Address) 619 Hanover St.

C. HAMILTON JONES, M. D.

15 Filed ....., 19 .....

1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 8th, 1930, that I last saw h.. alive on July 8th, 1930, and that death occurred, on the date stated above, at 1 1 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(daration) .....yrs. .....mos. 3 .....ds.

CONTRIBUTORY —

(Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted —

If not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. H. Campbell, M. D.

7/8, 1930 (Address) 830 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Zion Ct	July 10 1930
UNDERTAKER	ADDRESS
L. H. Brown & Son	108 W. Mont.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58647

CERTIFICATE OF DEATH

90 E 58647

1-PLACE OF DEATH

City of Baltimore: (No. 225 S. President St. 3-5 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Therese Paluzzi

(a) RESIDENCE NO. 225 S President St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Paluzzi

6 DATE OF BIRTH (month, day and year) Oct 27 1849

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	80	8	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) ?
(State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Delfina Paluzzi
(Address) York Pa

Filed JUL 9 1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation

Heart from exertion (duration) yrs. mos. Sudden ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenlon, M. D.

7/9 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys York pa	July 12 1930
20 UNDERTAKER	ADDRESS
Wendell & Dippel	300 E Lan St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 58648

HEALTH DEPARTMENT—CITY OF BALTIMORE

170 E 58648

CERTIFICATE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Carroll Park S. 21-29 WARD

2-FULL NAME Albert L. Jarbert

(a) RESIDENCE NO 1333 Hoffheimer ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shut Mtal Wkr
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Vincent Jarbert

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Abel

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Abel
(Address) 2859 Washington Blvd

15 Filed ....., 192 .....
C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows: Suicide - Pistol shot through head

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. W. Brantz, M. D. Coroner

July 7, 1930 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem DATE OF BURIAL 7/9 1930

20 UNDERTAKER Edward Fowler ADDRESS 359 Wash Blvd

CAUSE OF DEATH must be plainly written, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58649

CERTIFICATE OF DEATH.

REGISTERED NO. 161 E 58649

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 S Washington Ave ST. 4 WARD)

2-FULL NAME Jos. Szczeszek

(a) RESIDENCE NO. 405 S Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9. 30

7 AGE Years Months Days If LESS than 1 day hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Szczeszek

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Maryland

12 MAIDEN NAME OF MOTHER Carol Jendroszkiewicz

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

14 Informant Carol Szczeszek (Address) 405 S. Washington Ave

15 Filed JUL 9 - 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1930

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to July 9, 1930.

that I last saw him alive on July 9 1930

and that death occurred, on the date stated above, at 6.20 a m.

The CAUSE OF DEATH* was as follows:

Prematur Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. Lee Williamson M. D.

(Address) 801 Cathedral 7/9/30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 7/9 1930

UNDERTAKER William J. Lawlor ADDRESS 168 Caroline

CAUSE OF DEATH to print terms, so that it may be properly classified. Each statement of cause of death TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58650

E 58650 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122-001

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (No. 1600 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Chase

(a) RESIDENCE NO. 1027 Rice st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Selesman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 Filed JUL 9 1930 C. HOMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to July 6, 1930, that I last saw him alive on July 6, 1930, and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) [signature] M. D.

7-7, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL July 10 1930

UNDERTAKER Jesse A. Redden

ADDRESS 436 N. Biddle St

Spec.—2-29-28—L. F. S.—500 Bks.

E 58651 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58651

CERTIFICATE OF DEATH

REGISTERED NO. 8-45

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3003 Erdman ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Richards

(a) RESIDENCE NO. 3003 Erdman ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara E Richards

6 DATE OF BIRTH (month, day, and year) Oct 12 - 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
55	54	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Richards

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Callison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Clara E Richards

(Address) 3003 Erdman ave

15 Filed July 9 - 1930, 19 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 - 1930

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to July 8, 1930, that I last saw him alive on July 6, 1930 and that death occurred, on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) E Clark Simpson M. D.

7/8/1930 (Address) 1613 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: July 10 1930

UNDERTAKER: Robt J Turner — ADDRESS: 1242 E Broadway

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58652

CERTIFICATE OF DEATH.

X 57

E 58652

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 4-30 ST., WARD)

2-FULL NAME Mrs. Lulu J. Dwyer

(a) RESIDENCE NO. Park Heights Ave. ST., WARD

(Usual place of abode) Pikesville, Md. (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John A. Dwyer

6 DATE OF BIRTH (month, day, and year) Nov. 3, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County (State or country) Maryland

PARENTS

10 NAME OF FATHER Edwin Handy

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Mollie E. Gwynn

13 BIRTHPLACE OF MOTHER (city or town) Easton (State or country) Maryland

14 Informant Mr. John A. Dwyer (Address) Pikesville, Md.

15 Filed JUL 9 - 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8-1930

17 I HEREBY CERTIFY, That I attended deceased from July 4 -, 1930, to July 8 -, 1930, that I last saw her alive on July 8 -, 1930, and that death occurred, on the date stated above, at 11:45 Am.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus, 3 yrs duration,
Apoplexy (Paralysis of left side of body) 19 days duration.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia - hypostatic

(duration) yrs. mos. 3, ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical signs + symptoms with laboratory tests + autopsy.

(Signed) W. H. Varnedoe M. D.

7/8, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL July 10 1930

UNDERTAKER Joseph D. Cook

ADDRESS 1003 West Baltimore St.

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58653

CERTIFICATE OF DEATH

90 E 58653

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 641 W. Fayette ST. 20-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George E. Ittner

(a) RESIDENCE NO. 531 S. Smallwood St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Moulder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George E. Ittner

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Rankle

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Margaret M. Duckett

(Address) 531 S. Smallwood St.

15 Filed ..... 19 ..... HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930 to July 8, 1930, that I last saw h im alive on July 8, 1930 and that death occurred, on the date stated above, at 8 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

July 8, 1930 (Address) 753 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL July 10 1930

20 UNDERTAKER Joseph S. Cook

ADDRESS 1003 West Baltimore St.

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58654 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58654

CERTIFICATE OF DEATH.

REGISTERED NO. 167-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home - Infirmary ST. 12-50 WARD

2-FULL NAME Leila Durling Barnes

(a) RESIDENCE NO. 3201 Guilford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 23 hrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 7, 1930

7 AGE	Years	Months	Days	If LESS than 1 day 23 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md

(State or country)

PARENTS

10 NAME OF FATHER Clement Hilkins Barnes

11 BIRTHPLACE OF FATHER (city or town) Forest Hills

(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Leila Martin Scott

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland.

14 Informant Mother

(Address) 3201 Guilford Ave

15 Filed 7-9 1930 R. H. Jamison Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 8, 1930, that I last saw her alive on July 8, 1930, and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity (7th month)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) M. Elgin, M. D.

7/8. 1930 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 7/10 1930

20 UNDERTAKER Henry U. Mears & Sons

ADDRESS 803 N. Calvert St

FROM A very important. See instructions on back of certificate

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58655 (1-PLACE OF DEATH)

E 58655 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST., 9-17 WARD)

2-FULL NAME Alfred James

(a) RESIDENCE No Tarboro N C ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

TION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	Unk	known	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant [illegible]
(Address) 293 [illegible]

15 Filed ....., 192 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Date on which he was ready (in number exact) continued

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Pellagra

(duration) Several mos. ds.

18 Where was disease contracted if not at place of death? Tarboro N.C.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. Braun, M. D. Coroner

7-9, 1930 (Address) 2439 McElroy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tarboro N.C. Oakdale

DATE OF BURIAL 9 1930

20 UNDERTAKER John C. Miller

ADDRESS [illegible]

Spec.—1-30—M. & T.—250 Blks.

238627

E 58656

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58656

CERTIFICATE OF DEATH.

+ 129

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 7-4 ST. WARD)

2-FULL NAME Hannah Castley

(a) RESIDENCE NO. Westminster Apt. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Poste 1st 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	widowed

6 If married, widowed, or divorced HUSBAND of or) WIFE of Widow unknown

6 DATE OF BIRTH (month, day, and year) 8-27-79

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Frazier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Relative (Address) JOHNS HOPKINS HOSPITAL

Filed 7-9-1930. 12 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-9-30

17 I HEREBY CERTIFY, That I attended deceased from 7-3-, 1930, to 7-9-, 1930, that I last saw h alive on 7-9-, 1930, and that death occurred, on the date stated above, at 9.04 m.

The CAUSE OF DEATH* was as follows:

Cardiac hypertrophy, chronic nephritis
Cardiac failure during induction of
ether anaesthesia - Myocarditis interi.

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pletalein - Blood pressure

(Signed) H. S. Everett, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parsons Cemetery DATE OF BURIAL July 12 1930.

20 UNDERTAKER C. M. Waltz ADDRESS Wenfield Md.

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58657

CERTIFICATE OF DEATH

90 E 58657

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 Maryland Avenue ST. 12-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel A. Haubert

(a) RESIDENCE NO. 2023 Maryland Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) -------

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Haubert

11 BIRTHPLACE OF FATHER (city or town) ----

(State or country) -----

12 MAIDEN NAME OF MOTHER Catherine J. Edmunds

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Miss Teresa Bradley

(Address) 2023 Maryland Avenue

Filed JUL 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14- 1925 to July 9 1930,

that I last saw h[illegible] alive on July 5- 1930

and that death occurred, on the date stated above, at 3[illegible] a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cystitis Bilateral 1 hour

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? NA Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of specimen

(Signed) [signature], M. D.

7/9/30, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cemetery, Govans — DATE OF BURIAL 7/11 1930

20 UNDERTAKER Henry U. Mears & Son — ADDRESS 405 N. Calvert St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58658

CERTIFICATE OF DEATH

129 ✓

E 58658

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3227 Shannon Drive ST. 26-40 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Migan

(a) RESIDENCE NO. 3227 Shannon Drive ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

.a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Migan

11 BIRTHPLACE OF FATHER (city or town) County Wexford (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Kelly

13 BIRTHPLACE OF MOTHER (city or town) County Wexford (State or country) Ireland

14 Informant Mrs. Wm. H. Sauter

(Address) 3227 Shannon Drive

15 Filed JUL 9 1930, 19 H. [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1930, to July 7, 1930, that I last saw h[illegible] alive on July 6 (4:30 P.M.) 1930 and that death occurred, on the date stated above, at 3.30 P. m. Standard Time

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility - Arteriosclerosis Chronic Nephritis & Hypertension. (duration) 25 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? none Fraction.

What test confirmed diagnosis? Cessation of Cardiac

(Signed) Walter A. Anderson M. D.

7/9, 1930 (Address) 3300 Dudley Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL July 10 1930

20 UNDERTAKER [illegible] Cook

ADDRESS 1003 West Baltimore St.

IMPORTANT.—Fill in all items, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

100-001 V

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58659

CERTIFICATE OF DEATH

E 58659

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST., 7-4 WARD)

2-FULL NAME Laura Thompson

(a) RESIDENCE NO 1520 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	B	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23/1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		10	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Winslow Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Lottie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Lottie Thompson
(Address) 1520 Jefferson St

15 Filed 7-9-1930 by HAMPSON JAMES, M. D. Registrar

Pat

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? At Hopkins

What test confirmed diagnosis?

(Signed) [illegible], M. D. Coroner

7/9/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathay Cemetery

DATE OF BURIAL July 10 1930

20 UNDERTAKER Robert F. Williams

ADDRESS 1515 N. Eden St

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

D 1 11 a/pe.

E 58660 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 58660

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2266 Woodberry ST. 13-51 (WARD)

2-FULL NAME James E. Burnham

(a) RESIDENCE NO. 2266 Woodberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine C. Burnham

6 DATE OF BIRTH (month, day, and year) July 16-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman 078

(b) General nature of industry, business, or establishment in which employed (or employer) United R R

(c) Name of employer Company

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Burnham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Catherine Burnham

(Address) 2266 Woodbury

Filed JUL 10 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8-1930

17 I HEREBY CERTIFY, That I attended deceased from Abt June, 1927, to July 8, 1930,

that I last saw h[illegible] alive on July 7, 1930,

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Asthenia - Sclerosis

(duration) 3 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herbert Cahoon, M. D.

7/9, 1930 (Address) 1216 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 7/11 1930

UNDERTAKER Marcian Cook

ADDRESS 1217 St Paul

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 58661

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58661

CERTIFICATE OF DEATH.

131

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hosp.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 1-1 WARD)

2-FULL NAME Mary Lingenfelter

(a) RESIDENCE NO. 2931 Dillon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jno. Lingenfelter

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Packer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) ?

14 Informant Hosp Records.
(Address) Balto City Hosp.

15 Filed JUL 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-8-30

17 I HEREBY CERTIFY, That I attended deceased from 6-26-, 1930, to 7-8-, 1930, that I last saw h[illegible] alive on 7-8, 1930, and that death occurred, on the date stated above, at 10.40 P.m.

The CAUSE OF DEATH* was as follows:

Hydronephrosis rt & left
Hydroureter rt & left

(duration) Unknown ds.

CONTRIBUTORY Nephritis
(Secondary) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Fred M. Dunkerly, M. D.

, 19 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hadlown

DATE OF BURIAL 7/11 1930

20 UNDERTAKER Wilhelm Cook

ADDRESS 1217 E Fort Ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 58662 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 58662**

46

CERTIFICATE OF DEATH.

REGISTERED NO. 15-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3804 Barrington Road ST. 15 WARD)

2-FULL NAME Mrs Ella Thomas Smith

(a) RESIDENCE NO. 3804 Barrington Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ August Smith

6 DATE OF BIRTH (month, day, and year) August 5- 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min
55?	✓ 11	✓ 3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Severn - Anarundel Count - Maryland

PARENTS

10 NAME OF FATHER William T. Perkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey - U-S-A.

12 MAIDEN NAME OF MOTHER Mary Owens

13 BIRTHPLACE OF MOTHER (city or town) Severn (State or country) Anarundel Co. Md.

14 Informant Mrs Grace Perkins
(Address) 3804 Barrington Road

15 Filed OCT 10 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8-1930

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1928, to July 8, 1930, that I last saw her alive on July 6, 1930, and that death occurred, on the date stated above, at 10-40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastises to lungs

(duration) yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of July 28/1928

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Frank Kallex Morris, M. D.

, 19 (Address) 1129 Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 7/11 1930

20 UNDERTAKER William Cook

ADDRESS 1210 E Lord

Cor.—10-10-29—A Co.—100 Bks.

E 58663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1 √ E 58663

1-PLACE OF DEATH B.& O.R.R.Co.

City of Baltimore: (No. Locust Point Yards. St., 8-40 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank J.Stafford.

(a) RESIDENCE NO. 3309 Lyndale Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 1 mos. 8 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~Widowed or Divorced~~ HUSBAND of ~~WIFE of~~ May B. Stafford.

6 DATE OF BIRTH (month, day, and year) May 31, 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	70	1	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barge man.
(b) General nature of industry, business, or establishment in which employed (or employer) B.& O.R.R.Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER James Stafford.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary McDonald.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant May B.Stafford.(wife)
(Address) 3309 Lyndale Ave.

15 Filed ....., 19.... Registrar

JUL 10 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1930 192

17 I HEREBY CERTIFY, That, I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage.
Pulmonary Tuberculosis.
Arterio sclerosis.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

7/9, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 7/11 1930

20 UNDERTAKER Wilson Cook

ADDRESS 2178 E Lombard

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58664 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58664

CERTIFICATE OF DEATH.

REGISTERED NO. 135

1. PLACE OF DEATH Balto. City Hosp. 3-5 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2. FULL NAME Joseph K Shaw

(a) RESIDENCE NO. 1064 Granby ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married.

5a If married, widowed, or divorced HUSBAND of Annie Shaw (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~Oct~~ 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Hosp. Records.

(Address) Balto City Hosp.

15 FILED 10 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-9-30

17 I HEREBY CERTIFY, That I attended deceased from 7-7— 1930, to 7-9— 1930,

that I last saw him alive on 7-9- 1930,

and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of prostate

Acute Urinary Retention

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Fred M. Ohlemacher, M. D.

19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 7/12 1930

20 UNDERTAKER Fallhom Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 58665

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58665

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 22-30 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucille Knight

(a) RESIDENCE NO. 535 W. Lee ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond

(State or country) Va.

PARENTS

10 NAME OF FATHER William Knight

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Turner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-6-30

17 I HEREBY CERTIFY, That I attended deceased from 3-17-30, 19..., to 7-6-30, 19..., that I last saw her alive on 7-6-30, 19..., and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus.

(duration) 24 (life) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 1. Congenital. 2. Hospital.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

7-7, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 10 1930
UNDERTAKER Glen H. Troadwell	ADDRESS 1027 Hanover

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58666

CERTIFICATE OF DEATH

112 E 58666

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1135 Ridgely St. St., 21-31 Ward)

2-FULL NAME Elizabeth R. Kreipel.

(a) RESIDENCE NO. 1135 Ridgely St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 10 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced (or) WIFE of Leo J. Kreipel.

6 DATE OF BIRTH (month, day, and year) August [illegible], 1898

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	31	10	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER George W. Hagner.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Helen Smith.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) St. Louis Mo.

14 Informant Leo J. Kreipel. (husband)
(Address) 1135 Ridgely St.

15 Filed ..., 19.. C. HAMPSON JONES, Registrar

L 10 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to not death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion.

Acute dilatation of the Heart.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

7/9, 1930 (Address) 1017 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL July 10 1930

20 UNDERTAKER Fred A. Kramer & Co. ADDRESS 703 Hamilton

1-30—M. & T.—100 B—50L

E 58667

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58667

CERTIFICATE OF DEATH

REGISTERED NO. 100

(If death occurred in a hospital or institution, give NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hosp. WARD)

2-FULL NAME Bernard G. Davis

(a) RESIDENCE NO 2009 Druid Hill Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18-1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work nn
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frederick Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hazel Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hazel Davis

(Address) 2009 Druid Hill Ave

15 Filed 10 1930 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] Coroner, M. D.

19 1930 (Address) 506 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem

DATE OF BURIAL 7-10 1930

20 UNDERTAKER Daniel Exeter

ADDRESS 716 Ba ave.

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

58668 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 ✓ E 58668

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 21-31 ST. (RD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Spriggs

(a) RESIDENCE NO. 1010 Russell Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Spriggs

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1859?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70?	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER John Henry Spriggs

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Gent

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 7-9 1930 C. HENDERSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-8-30

17 I HEREBY CERTIFY, That I attended deceased from 7-3-30, 19..., to 7-8-30, 19...,

that I last saw him alive on 7-8-30, 19...,

and that death occurred, on the date stated above, at 4:20 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

7-9-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 7-10 1930

UNDERTAKER Daniel Easton

ADDRESS 916 Eutaw

FROM A very important. See instructions on back of this certificate

Spec.—1-30—M. & T.—250 Bks

E 58669 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58669

CERTIFICATE OF DEATH.

B/V

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1370 N. Stricker ST. 15-72 WARD)

2-FULL NAME Mary Ann E. Hall

(a) RESIDENCE NO. 1370 N. Stricker ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wallace Hall

6 DATE OF BIRTH (month, day, and year) 8-28-1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick to md

PARENTS

10 NAME OF FATHER Jacob Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Sarah E. Diggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Sarah E. Holland

(Address) 1370 N Stricker St.

15 Filed 7-10 1930 C. HAMPSON JONES, M. D. Registrar

10182

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-8-30

17 I HEREBY CERTIFY, That I attended deceased from 5-4- 1930, to 7-8- 1930, that I last saw her alive on 7-8- 1930, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Phthysis

(duration) yrs. 7 mos da.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & physical examination

(Signed) Frank Saunders, M. D.

7-9-1930 (Address) 1029 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 7/11 1930

UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Preastman St

Spec.—1-30—M. & T.—250 Bks.

E 58670 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58670

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto. City Hosp.

CITY OF BALTIMORE: (No. ..... ST. 76-27 WARD)

2-FULL NAME Frank J. Fay

(a) RESIDENCE NO. Unknown ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of) the late Mary Fay

Married 26-1880 Mar 24 1854

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
76	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Geo Fay

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Daniels

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Germany

14 Informant Hosp Records
(Address) Baltimore City Hosp.

15 Filed JUL 10 1930 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-8-30

17 I HEREBY CERTIFY, That I attended deceased from 5-8-, 1930, to 7-8, 1930, that I last saw him alive on 7-8-, 1930, and that death occurred, on the date stated above, at 8 45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left tonsil with local metastasis

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Fred M. Dunkum, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery G.A. Co.	July 11, 1930
20 UNDERTAKER Henry Hoeck Sons, Inc.	ADDRESS 1301 E Eager St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58671

CERTIFICATE OF DEATH

E 58671

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2409 Elsinore Ave. St., 15-61 (Ward)

2-FULL NAME Anna L. Stearns

(a) RESIDENCE NO. 2409 Elsinore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt L.

6 DATE OF BIRTH (month, day, and year) Jan 20-1855

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	75	5	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Louis Du Gar

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Mrs. Hoar

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Robt L. Stearns
(Address) 2409 Elsinore

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Conclusion of Labor
Work (duration) Unknown mos. ds.
CONTRIBUTORY (Secondary) Fell down steps
(duration) Unknown

18 Where was disease contracted if not at place of death? 2409 Elsinore
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H. B. Funk M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL July 12 1930

20 UNDERTAKER Geo W Little — ADDRESS 2700 Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Sep—2-20-28—1-29-30—500 Bks.

E 58672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 58672

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 S. Linwood Ave ST 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME BERNARD KAMINSKI.

(a) RESIDENCE NO. 714 S. Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 8 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 21-1908.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	8	20	18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist help 631

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Tin Decorading Co. Baltimore.

9 BIRTHPLACE (city or town) MD.
(State or country)

PARENTS

10 NAME OF FATHER Lawrance Kaminski,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Marie Augustiniak,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Mrs. Marie Kaminski, (MOther)

(Address) 714 S. Linwood Ave

15 Filed JUL 10 1930, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/9/30

17 I HEREBY CERTIFY, That I attended deceased from 5/5, 19 30, to 7/9, 19 30, that I last saw him alive on 7/7, 19 30 and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Endocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) Dan Jamieson M. D.

7/10, 1930 (Address) 122 S Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ST. STANISLAUS CEM.,

DATE OF BURIAL July 12. 19 30.

20 UNDERTAKER M. F. Sadowski.

ADDRESS 2215 Elhaven

Important. See instructions on back of certificate.

Cor.—10-10-20—A Co.—100 Bks.

E 58673

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH P.O. Building

REGISTERED NO. E 58673

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Emergency Hosp. [illegible] St., 5-8 Ward)

2-FULL NAME A. Lee Morgan (alias Morgan)

(a) RESIDENCE NO. 614 East St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Morgan

6 DATE OF BIRTH (month, day, and year) June 6, 1905

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	24	1	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Potts & Callahan
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER A. Morgan

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unk
(State or country)

14 Informant Bertha Morgan wife
(Address)

15 Filed ....., 19.... G. HAMPSON JONES, M. D. Registrar

J 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract. skull - Caused by Mach. accidentally falling from scaf. at P.O. Building

(duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted? If not at place of death? P.O. Building

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Phillips, M. D.

July 10 1930 (Address) 1039 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rices Va.

DATE OF BURIAL July 10 1930

20 UNDERTAKER Mrs. R.G. Ellicott

ADDRESS 1745 Ashland Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58674

CERTIFICATE OF DEATH

74001 E 58674

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1136 W Pratt ST. 18-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Hurley

(a) RESIDENCE NO. 1136 W Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) ~~WIFE OF~~ Widow.

6 DATE OF BIRTH (month, day, and year) June 1, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Michael Donovan

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Margaret Nigro

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Margaret Hagan (Address) 1136 W. Pratt St.

15 Filed 10 1930 C. HAMPSON JONES, M. D. Registrar by [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/8/30

17 I HEREBY CERTIFY, That I attended deceased from 5/1/30 19..., to 7/8 19 30, that I last saw h.. alive on 7/8 30, 19..., and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ...yrs...mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward J. Ferry, M. D.

7/10/1930 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Cathedral Cem. DATE OF BURIAL 7/11 1930

20 UNDERTAKER John J. Donaldson ADDRESS 901 Lexington

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58675

CERTIFICATE OF DEATH.

129

E 58675

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen Hosp. (St.) 14-24 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice L. Carroll

(a) RESIDENCE NO. 328 S. Parrish ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
f	(w)	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Carroll

6 DATE OF BIRTH (month, day, and year) 9/19/1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER George Wilkens

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Charles E. Carroll

(Address) 328 S. Parrish

15 Filed JUL 19 1930 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/10 1930

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to July 10, 1930, that I last saw h.er alive on July 10, 1930, and that death occurred, on the date stated above, at 5-a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Nephritis

(duration) 0 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 328 S. Parrish

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Zieler Pronosticman, M. D.

, 19 (Address) West Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 7/12 1930

20 UNDERTAKER John F. Cowan & Son

ADDRESS 901 Hollins

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

GEORGE DOUGLAS HANDY

E 58676 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 58676

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 4619 Edmondson Ave ST., 27-56 WARD)

2-FULL NAME George Douglas Handy

(a) RESIDENCE NO. 4619 Edmondson Ave ST., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W B.

5 ~~Single, Married, Widowed,~~ or Divorced. (Write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Johnson

6 DATE OF BIRTH (month, day, and year) April 30-1910

7 AGE Years 20 Months 2 Days 9

If LESS than 1 day old ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer 914 Richmond St

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George H Handy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hattie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George Handy (Address) 4619 Edmondson Ave

15 FILED OCT 10 1930, 19 R.H.G. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/9 1930

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to 7/9/30, 19 30, that I last saw h alive on 7/9/30, 19 30, and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

Extra Pulmonary Tuberculosis of Larynx

(duration) 3 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ↓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) George H Handy, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL July 19 30

20 UNDERTAKER Samuel E. Stansbury

ADDRESS 1 E Biddle

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 58677 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58677

CERTIFICATE OF DEATH.

113

REGISTERED NO. 25-32

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2009 Annapolis Rd ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Collision Jr.

(a) RESIDENCE NO. 2009 Annapolis Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James Collision

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Regie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant James Collision Jr. (Address) 2009 Annapolis Rd.

15 Filed JUL 10 1930 C. HOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10-1930.

17 I HEREBY CERTIFY, That I attended deceased from June 25 1930, to July 10, 1930, that I last saw him alive on July 8, 1930, and that death occurred, on the date stated above, at 1130 A. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Morley Young, M. D.

July 10 1930 (Address) 724 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Luther Glen, Va.

DATE OF BURIAL 7/10/1930

20 UNDERTAKER John G. Connelly

ADDRESS Essex

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58678 — REGISTERED NO. 49 — E 58678

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3635 Chesterfield ave St. 26-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry G Klein

(a) RESIDENCE NO. 3035 Chesterfield ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

If married, widowed, or divorced, HUSBAND of (or) WIFE of: Sophia Klein

6 DATE OF BIRTH (month, day, and year): June 26 1851

7 AGE: Years 79 — Months — Days 13 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Born on Ocean comming to United States

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs E. Mc Cabe

(Address) 2752 Mosher st

15 10-1930 C. H. [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 — 1930

17

I HEREBY CERTIFY, That I attended deceased from June 7, 1930, to June 8, 1930, that I last saw h[illegible] alive on June 8, 1930 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

Bleeding - Vesical.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Prostate Hypertrophy or Bladder Tumor (?)

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Rectal Examination

(Signed) Charles A. Levy, M. D.

June 10, 1930 (Address) 1 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery

DATE OF BURIAL: July 12 1930

20 UNDERTAKER: Robt T Turner

ADDRESS 1542 N. Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58679

CERTIFICATE OF DEATH

74-001 E. 58679

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1538 N Bond ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Emile Markolf

(a) RESIDENCE NO. 1538 N Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Letter Carrier - 1 0 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Post Office Dept. U.S.

9 BIRTHPLACE (city or town) Baltimore - Md

(State or country)

PARENTS

10 NAME OF FATHER Henry Markolf

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Bertha Liest

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Bertha Markolf, sister

(Address) 1538 N Bond St.

15 Filed ... 19 C. HAMPSON JONES, M. D. Registrar

JUN 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-8-30.

17 I HEREBY CERTIFY, That I attended deceased from 2/13/30, 19..., to 7-8, 1930, that I last saw h. alive on 7-8-, 1930 and that death occurred, on the date stated above, at 8.30 P. m. E.S.Time.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Cerebral -

(duration) yrs. 4 mos. 25 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 2 1/2 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) George Abner Bardeen, M. D.

7/9, 1930 (Address) 1517 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Loudon Park

DATE OF BURIAL 7/11 1930

20 UNDERTAKER P. H. Turner

ADDRESS 1442 N Broadway

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58680

E 58680

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Providence Hosp. St. 14-20 Ward)

2-FULL NAME Wm M. Murray

(a) RESIDENCE NO. 1724 McCulloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 7-1904

7 AGE: Years 25 | Months 11 | Days 2 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Bell Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER: Hunter Murray

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER: Willie McClean

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant: Willie Murray
(Address) 1724 McCulloh St.

15 Filed 10 1930 19 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 7th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and Autopsy (Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Spontaneous
(duration)

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leo Kaltenbach, M. D.
July 9 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

17 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL 7/12/1930

20 UNDERTAKER: Jos. Geo. H. Holland — ADDRESS 1631 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58681 ✓

161-001

E 58681

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hosp. ST. 25-32 WARD

2-FULL NAME Baby Girl Reese

(a) RESIDENCE No. 2246 Sidney ave - west Port ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs mos. ds./hr How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7-4-30

7 AGE — Years — Months — Days — If LESS than 1 day, / hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Arthur J Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Marie Noll.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mother

(Address) 2246 Sidney ave.

Filed 7 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-4 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-4-30, 19 ..., to 7-4, 19 30.

that I last saw h[illegible] alive on 7-4-30, 19 ...

and that death occurred, on the date stated above, at 2:00 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Maternal Nephritis

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Exam

(Signed) [illegible] M. D.

, 1930 (Address) Union Mem Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS

JUL 1 01930

Pat. Wm. E. Woodall

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58682

CERTIFICATE OF DEATH

E 58682

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 920 N. Payson St. 16-22 (Ward)

2-FULL NAME Amelia L. Holmes

(a) RESIDENCE NO. 920 N. Payson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edgar C. Holmes

6 DATE OF BIRTH (month, day, and year) Aug 17-1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	44	10	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Cornelius Neal

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Barrie Otter.

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Edgar C. Holmes
(Address) 920 N. Payson St.

15 Filed 7-16-1930 H. LLOYD JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden

(duration) hr. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What confirmed diagnosis? Apoplexy

(Signed) H. Lloyd Jones, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL July 17 1930

20 UNDERTAKER Avery A. Ehlen

ADDRESS 1444 W. Fayette

Spec.—8-16-29—L. F. S.—100 Blks.

E 58683 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 58683

REGISTERED NO.....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2036 Linden ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie G. Dennis

(a) RESIDENCE NO. 2036 Linden ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Dennis

6 DATE OF BIRTH (month, day, and year) Jany 16 1852

7 AGE Years 77 | Months 5 | Days 28 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work notary

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jos. Krueup

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Jane M. Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Anne L. Dennis (Address) 2036 Linden ave

15 Filed 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to July 9, 1930, that I last saw h. alive on July 8, 1930, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical examination

(Signed) Frank Thomas, M. D.

. 19 (Address) 2305 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mt | DATE OF BURIAL July 12 1930

20 UNDERTAKER John Ellicott Sons Inc Funeral Directors | ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 58684

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 58684

1—PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Fayette & Calhoun ST. 16-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. John Krauss

(a) RESIDENCE NO. 2952 Presstman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 27 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	72	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O. R.R.

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Wolfgang Krauss

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Bathina Fruchtel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Henry Shilles

(Address) 2952 Presstman St.

15 Filed OCT 10 1930, H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-10-30

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to July 10, 1930, that I last saw him alive on July 10, 1930 and that death occurred, on the date stated above, at 1:25 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) Many yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar Punctures

(Signed) W. C. Schreiber, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL JUL 12 1930, 19

20 UNDERTAKER Geo H. Little

ADDRESS 2700 EDMONDSON AVE.

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

58685

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1329 E 58685

REGISTERED NO.

1-PLACE OF DEATH South Baltimore Gen Hospital

CITY OF BALTIMORE: (NO. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Grooms

(a) RESIDENCE NO. 239 N. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Florence Grooms

6 DATE OF BIRTH (month, day, and year) Feb 6. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cincinnati Ohio

PARENTS

10 NAME OF FATHER Richard Grooms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Agnes Magoun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mrs Annie C. Marshall (Address) 239 Bentalow St

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-10-30

17 I HEREBY CERTIFY, That I attended deceased from 5-31- , 1930 to 7-10 , 1930,

that I last saw h[illegible] alive on 7-10 , 1930,

and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arterio sclerotic cardio Renal Disease (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7/2/30

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph D. Laukaitis M. D.

(Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL JUL 12, 1930

20 UNDERTAKER Geo H Little

ADDRESS 2700 EDMONDSON AVE.

1-30—M. & T.—100 B—50L.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58686

CERTIFICATE OF DEATH

185 ✓ E 58686

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 9-18 WARD)

2-FULL NAME Stephen Tagg

(a) **RESIDENCE** NO 1816 Asquith St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabella V.Tagg

6 DATE OF BIRTH (month, day, and year) Feb 7/1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	5	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Paperhanger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto.Co., Md.

PARENTS

10 NAME OF FATHER Ethelbert Tagg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co., Md.

12 MAIDEN NAME OF MOTHER Elizabeth Stellings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Isabelle G. And ews
(Address) 2ashington D.C.

15 Filed 7/21/30 C. HARRISON JONES, Registrar

101930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Shock- Fractured rt. arm & shoulder
Internal Chest Injuries. (Scaffold collapsed upon which he was painting outside of house at Evergreen & (duration) ds.

CONTRIBUTORY (Secondary) Winthrop Aves. Accidental (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Bolton, M. D. Coroner

7/21/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL July 12 '30

20 UNDERTAKER Wm. H. Sards Co. — ADDRESS 412 - W. St. N.E. Wash. D.C.

TION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 58687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 E 58687

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Walters

(a) RESIDENCE NO 220 S. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9/30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			about 6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Andrew Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Grace Tully

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Andrew Walters
(Address) 220 S. Chester St

15 Filed JUL 11 1930 C. HUDSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity- 6 1/2 Mons Gestattion

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Paul, M. D. Coroner

7/10/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	July 10 1930
20 UNDERTAKER	ADDRESS
John M. Weber	410 S. Chester

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 58688

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58688

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 7-10 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wells

(a) RESIDENCE NO. 517 N. Port ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) Aug. 2, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jennie Eligah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

7-17-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-9-30

17 I HEREBY CERTIFY, That I attended deceased from 6-12-30, 19..., to 7-9-30, 19..., that I last saw him alive on 7-9-30, 19..., and that death occurred, on the date stated above, at 7:15 P m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic, without oedema.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Vincent's Angina

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

7-10, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL July 10 1930

20 UNDERTAKER John Reid ADDRESS 1008 Orleans

IF NOT VERY IMPORTANT DO NOT FOLLOW DIRECTIONS OF DATE OF STRIKING

Spec.—1-30—M. & T.—250 Bks.

E 58689

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58689

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Eva Krongard

(a) RESIDENCE NO. 1225 E. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 12-1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Lady

(b) General nature of industry, business, or establishment in which employed (or employer) Read Drug

(c) Name of employer Stock 1067

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Morris Krongard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Fordogen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Morris Krongard

(Address) 1225 E. Eden St

15 Filed JUL 11 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/24, 1930, to 7/10, 1930, that I last saw her alive on 7/10, 1930, and that death occurred, on the date stated above, at 3.30 P.M. EST

The CAUSE OF DEATH* was as follows: Heart

Chronic Valvular Disease

Mitral Stenosis & Insufficiency

Aortic Stenosis & Insufficiency

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Milton B. Crook, M. D.

7/11 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rosedale DATE OF BURIAL July 11 1930

UNDERTAKER Jack Lewis 1439 E Eden ADDRESS

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58690

CERTIFICATE OF DEATH.

90 E 58690

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1015 Whitelock St. ST. 13-59 (WARD)

2-FULL NAME Louis Krohman

(a) RESIDENCE No. 1015 Whitelock St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Edith Krohman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Edith Krohman

(Address) 1015 Whitelock St

15 Filed 1-1 1930 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9-30

17 I HEREBY CERTIFY, That I attended deceased from , 1927, to July 9, 1930, that I last saw h.... alive on July 9, 1930, and that death occurred, on the date stated above, at 8:20 P m.

The CAUSE OF DEATH* was as follows:

Prostatectomy (Operation) Chronic Cystitis. Myocardities

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Coronary artery disease Lingua bacteria (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No (not for 2 yrs)

What test confirmed diagnosis? Physical Exam.

(Signed) Frank R. Smith, M. D.

, 19 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship DATE OF BURIAL 7/11 1930

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Baltimore St

Spec.—1-30—M. & T.—250 Blks.

E 58691 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 58691

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 20-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ulyses Grimes

(a) RESIDENCE No. 1830 Fremont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Sept. ? 1870

7 AGE: Years: About 60 (59) | Months: (10) | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 136 RR

(b) General nature of industry, business, or establishment in which employed (or employer): 073

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Carroll Co Md

PARENTS

10 NAME OF FATHER: Amon Grimes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co Md

12 MAIDEN NAME OF MOTHER: Laura Crist

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Mrs Anna E Hodelmeister

(Address) 811 N Fulton Av

15 Filed 7-11 1930 19 JOHNSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-10-30

17

I HEREBY CERTIFY, That I attended deceased from 7-9, 1930, to 7-10, 1930,

that I last saw him alive on 7-10, 1930,

and that death occurred, on the date stated above, at 10.20 a. m.

The CAUSE OF DEATH* was as follows:

Heart disease - mitral insufficiency

Myocardial insufficiency without edema.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pneumonia, Hypostatic

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clin. Signs & Symps. & autopsy findings.

(Signed) J. C. Flynn Jr., M. D.

7/10, 1930 (Address) Univ. Hosp. City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

UNDERTAKER: Robert Brooks & Son

DATE OF BURIAL: 7-12 1930

ADDRESS: Cathcart Hollins

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58692

CERTIFICATE OF DEATH

90

REGISTERED NO. E 58692

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1218 Whatcoat St. 16-22 Ward)

2-FULL NAME Thos E. Rustin

(a) RESIDENCE NO. 1218 Whatcoat St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 24 - 1879

7 AGE: Years 50 | Months 8 | Days 14 15 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) St Marys Co
(State or country) Md

PARENTS

10 NAME OF FATHER Geo Rustin

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Georgiana Adams

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Sarah Rustin
(Address) 1365 N Gilmor

15 Filed ..... 19.. C. ATKINSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. B. Leuk M. D.
Coroner
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 11 1930
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1303 Presstman St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58693

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58693

CERTIFICATE OF DEATH.

REGISTERED NO. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 344 S. Newkirk ST. ~~Nov~~ 37 WARD

2-FULL NAME Frank Yaeger

(a) RESIDENCE NO. 344 S. Newkirk ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of the late Katherine Yaeger

6 DATE OF BIRTH (month, day, and year) Mch 10th 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) Hungary (State or country)

PARENTS

10 NAME OF FATHER Frank Yaeger

11 BIRTHPLACE OF FATHER (city or town) Hungary (State or country)

12 MAIDEN NAME OF MOTHER Katherine Lieb

13 BIRTHPLACE OF MOTHER (city or town) Hungary (State or country)

14 Informant Frank Yaeger (Son)

(Address) 344 S. Newkirk St

15 Filed JUL 11 1930 C. HAMILTON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to July 8th 1930.

That I last saw him alive on July 8th 1930

and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows: Cerebral Accident or Coronary Thrombosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension Arteriosclerosis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. H. Greenstreet M.D.

(Address) 4613 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dale Lawn Cemetery — DATE OF BURIAL July 11th 1930

20 UNDERTAKER M. Lilly & Sons Inc. — ADDRESS 403 S. Wolfe St

Spec.—1-30—M. & T.—250 Blks.

E 58694 E 58694

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 N. Kresson ST., 26 WARD) 26-39

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances V. Schenning

(a) RESIDENCE No. 12 N. Kresson ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3rd 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER August Schenning

11 BIRTHPLACE OF FATHER (city or town) Buffalo N.Y.
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Vanlieck

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant August Schenning
(Address) 12 N. Kresson St.

15 Filed JUL 11 1930 C. HAMILTON JONES, Registrar By:

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 9, 1930, that I last saw h[illegible] alive on July 9, 1930 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Insipidus Typ I

(duration) 2 yrs. 4 mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Enteritis. Colitis.

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed H. C. Wm Knudtson, M. D.

July 9, 1930 (Address) 3508 Bank St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem

DATE OF BURIAL July 11 1930

20 UNDERTAKER M. D. Lilly & Zeiler Inc

ADDRESS 4033 S. Wolfe

IMPORTANT: See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 58695

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58695

92

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 116 S Broadway ST., 3-4 (WARD)

2-FULL NAME Bettie Cohn

(a) RESIDENCE No. 116 S. Broadway ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Amelia Co Va

PARENTS

10 NAME OF FATHER Henry P. Cohn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fannie Kaufmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joel Cohn

(Address) 116 S. Broadway

Filed July 11 1930, 19[illegible] at [illegible] M. G. HAMPSON DORSEY, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10-30

17 I HEREBY CERTIFY, That I attended deceased from July 9- 1930, to July 10- 1930, that I last saw h[illegible] alive on July 10 1930, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilation (Coronary Thrombosis)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Max Brunet, M. D.

, 19 (Address) 125 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew

DATE OF BURIAL 7/10 1930

20 UNDERTAKER Jack Levis 1439 Eastern Ave

ADDRESS

TION is very important. See instructions on back of certificates.

Cor.—12-9-35—A Co.—200 Bks.

E 58696

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-71 E 58696

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hospital St. 27-41 Ward)

2-FULL NAME Charles Joseph O'Neill

(a) RESIDENCE NO. 4238 Nicholas Ave. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret O'Neill

6 DATE OF BIRTH (month, day, and year) May 7, 1906

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	24	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Fairfield Western Maryland Dairy

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER James J. O'Neill

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Frazier

13 BIRTHPLACE OF MOTHER (city or town) Washington

(State or country) D. C.

14 Informant Mr. William E. O'Neill

(Address) 4238 Nicholas Ave.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.

Registrar

JUL 11 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto accident in which he was struck by a car which ran over him & then passed along side & fell

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Auto Accident

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Jones M. D.

(Coroner)

7/9, 1930 (Address) 2939 McElderry Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Arlington Mill Phila Pa

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

Date of Burial 7/12 1930

20 UNDERTAKER Joseph H. Cook

ADDRESS 1003 West Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Fill statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

KOPP

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58697

CERTIFICATE OF DEATH.

91-002 E 58697

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1110 N Fulton ave (WARD) 16-22

2-FULL NAME Eleanora Elinora L. Kopp

(a) RESIDENCE NO. 1110 N Fulton ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Theodore L. Kopp.

6 DATE OF BIRTH (month, day, and year) 10-20-1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Manchester,
(State or country) Carroll Co. Md

PARENTS

10 NAME OF FATHER John Krantz

11 BIRTHPLACE OF FATHER (city or town) Manchester
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Everhart

13 BIRTHPLACE OF MOTHER (city or town) Manchester
(State or country) Md.

14 Informant Miss Fannie L. V. Kopp
(Address) 1110 N Fulton Ave.

15 C. HAMPSON JONES, M. D.
Filed ....., 19..... Registrar

L 11930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1930

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to July 10, 1930, that I last saw h[illegible] alive on July 9, 1930, and that death occurred, on the date stated above, at 7 IV a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

about 8 yrs. mos ds.
(duration)

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. H. Duvall, M. D.

7/10, 1930 (Address) 1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park Cem — DATE OF BURIAL July 12, 1930

20 UNDERTAKER Joseph D Cook — ADDRESS 1003 Harl. St.

CAUSE OF DEATH. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

238741
E 58698

HEALTH DEPARTMENT—CITY OF BALTIMORE

1/2
118-0 E 58698

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 7-13 WARD)

2-FULL NAME Jane Fisher

(a) RESIDENCE NO. 815 N. Wolfe ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Apr-28-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Conrad Fisher

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Jane Rapp

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 11 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-11-1930

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to July 11, 1930, that I last saw her alive on July 11, 1930, and that death occurred, on the date stated above, at 1 49 A m.

The CAUSE OF DEATH* was as follows:

Acute intestinal obstruction from atypical intestinal intussusception

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 7-8-30

Was there an autopsy? Yes

What test confirmed diagnosis? Usual observations

(Signed) George D. Tenney, M. D.

July 11th 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel. Cem.

DATE OF BURIAL July 14, 1930

UNDERTAKER George W. Zirkler

ADDRESS 1737 E Eager St

Spec.—1-30—M. & T.—250 Blks

E 58699 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58699

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2046 E. Eager St. 1-19 Ward)

2-FULL NAME Katharine Hutton

(a) RESIDENCE NO. 2046 E. Eager St., [redacted] Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Hutton

6 DATE OF BIRTH (month, day, and year) Feb 5-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John L. Smerbank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs Virginia Peters

(Address) 2044 E. Eager St.

15 Filed JUL 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930 to July 8 1930,

that I last saw [redacted] on July 4 1930,

and that death occurred on the date stated above, at 3.55 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [redacted], M. D.

1930 (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL July 12 1930

20 UNDERTAKER George N. Zickler

ADDRESS 1737 E. Eager St

TION IS very important

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58700

E 58700

CERTIFICATE OF DEATH

REGISTERED NO. 15-22

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1309 Shuter ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lavinia Brooks

(a) RESIDENCE NO. 1309 Shuter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Brooks

6 DATE OF BIRTH (month, day, and year): Apr. 1877

7 AGE: Years 53 | Months 3 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Marys Co Md

PARENTS

10 NAME OF FATHER: John Bowsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Matilda Duke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Carrie Brooks

(Address) 1309 N Shuter St

15 Filed JUL 11 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10/30

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1930, to July 10, 1930, that I last saw her alive on July 10, 1930, and that death occurred, on the date stated above, at 5:55 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arthritis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Tuey M. D.

7/16, 1930 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn DATE OF BURIAL July 12th 1930

UNDERTAKER: Clarence E Wentz ADDRESS Cockeysville Md

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58701 129 E 58701

CERTIFICATE OF DEATH

REGISTERED NO. 24-35

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1344 Gawson ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martin J. Doran

(a) RESIDENCE NO. 1344 Gawson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Doran

6 DATE OF BIRTH (month, day, and year) Oct. 17-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	22 12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. 1930

(b) General nature of industry, business, or establishment in which employed (or employer) Stationary Engineer

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Michael Doran

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mary Sweeney.

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Margaret Doran

(Address) 1344 Gawson St

15 Filed ..... 19 ..... C. HAMILTON JONES, M. Registrar

1 1 1928

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9-1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to July 9, 1930, that I last saw him alive on July 8, 1930 and that death occurred, on the date stated above, at 1055 a.m.

The CAUSE OF DEATH* was as follows:

Uraemia. 3 days.

Hypertension Myocarditis

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 1 mos. 8 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No

What test confirmed diagnosis? Uraemia

(Signed) Thos. Fa Stevens, M. D.

7/9, 1930 (Address) 2828 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL July 12 1930

20 UNDERTAKER Thos. L. Stevens

ADDRESS 1501 E Fort Ave

Spec.—1-30—M. & T.—250 Blks.

E 58702 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58702

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 3-5 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Steve Boyko Marck

(a) RESIDENCE NO. 124 S. Exeter st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Marck

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Ship building

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Paul Marck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records (Address)

15 Filed ....., 19 ..... Registrar C. HAMPSON JONES, M. D.

JUL 11 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1930, to July 10, 1930, that I last saw him alive on July 10, 1930, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Thos Shrader, M. D.

7-10-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rosemont Independent STONY RUN Md. DATE OF BURIAL July 12/1930 19

UNDERTAKER George A. Weber 705 E Lanvale st. ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 58703

E 58703 HEALTH DEPARTMENT—CITY OF BALTIMORE

113

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Shakespeare ST. 24 WARD)

2-FULL NAME Bernard S. Lowinski

(a) RESIDENCE No. 1625 Shakespeare ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan- 9-1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant Child

(b) General nature of industry, business, or establishment in which employed (or employer) No

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER John Lowinski

11 BIRTHPLACE OF FATHER (city or town) Poland.
(State or country)

12 MAIDEN NAME OF MOTHER Joanna Zajanc

13 BIRTHPLACE OF MOTHER (city or town) Poland.
(State or country)

14 Informant John Lowinski
(Address) 1625 Shakespeare street

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/11/30

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to July 11, 1930, that I last saw h.. alive on July 11, 1930, and that death occurred, on the date stated above, at 8 9 m.

The CAUSE OF DEATH* was as follows:

Convulsions
Entero-Colitis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

7/11, 1930 (Address) 2578 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery

DATE OF BURIAL July 12 1930

ADDRESS

20 UNDERTAKER George A. Weber 705 S. Amity st

C. HARRISON JONES, M.D.

JUL 11 1930

Registrar

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58704 — CERTIFICATE OF DEATH. — E 58704

× 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 4-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon C. Gibbons

(a) RESIDENCE NO. Relay, Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced (HUSBAND) of or) WIFE of Lillian C. Gibbons

6 DATE OF BIRTH (month, day, and year) Dec 16th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45	46	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 67

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer B. & O. R.R.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Lillian C. Gibbons

(Address) Rolling Road, Relay

15 Filed 7-11 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/10/30

17

I HEREBY CERTIFY, That I attended deceased from July 3, 1930, to July 10, 1930, that I last saw him alive on July 10, 1930, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, general.

Arteriosclerosis, Cerebral

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T. J. Lynn Jr., M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 7/12/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 W Pratt St

HON. S. HARRISON JONES, M.D.

HON. S. HARRISON JONES, M.D. Commissioner of Health.

Very important. See instruction on back of certificate.

1-30—M. & T.—100 B—50J

E 58705

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58705

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hos ST., 12-49 WARD)

2-FULL NAME Edw. Brennan

(a) RESIDENCE NO Woodensburg ST., Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wr.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliz Brennan

6 DATE OF BIRTH (month, day, and year) Aug-11-1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	3	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Londendale Coal Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jas J. Brennan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliz Dempsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Elizabeth Brennan

(Address) Woodensburg Md

15 Filed DEC 11 1930 C. HARRISON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: While walking along road free unto motor Car

(duration) Hack Struck yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Woodensburg Md

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Surg & Phy

(Signed) L Stamm Coroner, M. D.

11, 1930 (Address) 2939 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

UNDERTAKER William Cook

DATE OF BURIAL 12/12 1930

ADDRESS 1217 St Paul

SECTION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58706

CERTIFICATE OF DEATH.

E 58706

REGISTERED NO. 16 22 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS ST. WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Ella Slocum.

(a) RESIDENCE NO. 1029 N. Vincent ST., WARD (If non-resident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored.	Divorced.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Slocum.

6 DATE OF BIRTH (month, day, and year) April 23, 1879.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	2	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook. Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER David Griffin.
11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)
12 MAIDEN NAME OF MOTHER Georgianna Moore
13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Records
(Address) BALTIMORE CITY HOSPITALS

15 Filed JUL 10 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 8, 1930, that I last saw her alive on July 8, 1930, and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:
Hemorrhage into cerebrum
(duration) yrs. mos 9 ds.
CONTRIBUTORY (Secondary) Hypertension unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1. Hospital 2. Home?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical exam.
(Signed) Paul Padget. M. D.
7-10, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL
DATE OF BURIAL JUL 11 1930
ADDRESS

20 UNDERTAKER
[illegible] HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Blks

E 58707 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 E 58707

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST., 113 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Hurtt

(a) RESIDENCE NO. 922 Rutland Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 097

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Robert Wolferd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records Of
(Address) Balto. City Hosp.

Filed JUL 11 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-7-30

17 I HEREBY CERTIFY, That I attended deceased from 5-16-29, 19..., to 7-7-30, 19..., that I last saw her alive on 7-7-30, 19..., and that death occurred, on the date stated above, at 6:15 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum.

(duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) Syphilis of central Nervous System (duration) UNKNOWN. yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Exam Microscopic.

(Signed) Paul Padget. M. D.

7-10. 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JUL 11 1930

UNDERTAKER Commissioner Health

ADDRESS .....

Spec.—1-30—M. & T.—250 Bks.

E 58708 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 58708

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 1627 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie Lee

(a) RESIDENCE NO. None ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Lee

6 DATE OF BIRTH (month, day, and year) 1903 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer C.W.O

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Dover (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1930, to July 7, 1930, that I last saw him alive on July 7, 1930, and that death occurred, on the date stated above, at 12.05 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

7-7-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JUL 11 1930 19

20 UNDERTAKER Commissioner Health

ADDRESS

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58709

CERTIFICATE OF DEATH

E 58709

REGISTERED NO. 31 E 58709

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 N. Chapel St. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elijah Stewart

(a) RESIDENCE NO 133 N. Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle Srewart

6 DATE OF BIRTH (month, day, and year) July 30-1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	11	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South America

PARENTS

10 NAME OF FATHER Hubert Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Myrtle Stewart
(Address) 133 N. Chapel St

15 Filed 1930 193 Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hemorrhage & history

(Signed) Coroner, M. D.

7/5/30 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JUL 7 1930 19

UNDERTAKER Commissioner Health.

ADDRESS

JOHNS HOPKINS M. D.

ATTENTION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 58710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 58710

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital St. 17-24 Ward)

2-FULL NAME Norman Carter

(a) RESIDENCE NO. 317 Orchard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	about 76			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

19 ... C. HAMPSON JONES, M. D., Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) ..yrs. 6 mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

7-6-1930 (Address) 708 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JUL 11 1930

20 UNDERTAKER: Commissioner Health

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58711

CERTIFICATE OF DEATH

9 E 58711

1-PLACE OF DEATH Pronounced Dead at

City of Baltimore: (No. Balto City Hospital St., 3-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Brady

(a) RESIDENCE NO. 1415 Eastern Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	about 60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work vagrant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) unknown
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant
(Address)

15 Filed JUL 11 1930 HAMILTON JONES, M. D. Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1415 Eastern

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James I M Hanlon, M. D.

July 2 1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	JUL 11 1930 19
UNDERTAKER Commissioner Health.	ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 58712

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. E 58712

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 940 Wash Blvd St. 1-29 (WARD)

2-FULL NAME Baby Girl Horseman

(a) RESIDENCE NO. 940 Wash. Blvd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Baltimore

PARENTS

10 NAME OF FATHER Ernest Horseman

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Alvina Hunley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant (Address)

15 Filed JUL 1 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 7, 1930, that I last saw him alive on July 7, 1930, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Premature birth

24 Hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Gross Dig —

(Signed) David A. Stewart, M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL JUL 11 1930

20 UNDERTAKER C. Hampton Jones, M. D. Commissioner Health. — ADDRESS

JUL 11 1930 THE MORGUE

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58713

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. E 58713

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 829 N. Gross St (St.) 21-29 (Ward)

2-FULL NAME Emma A. Mertz

(a) RESIDENCE NO. 829 N Gross St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John J Mertz

6 DATE OF BIRTH (month, day, and year): April 2 1862

7 AGE: Years 68 | Months 3 | Days 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lancaster Co Pa

PARENTS

10 NAME OF FATHER: John Wesley King

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): John J Mertz 829 N Gross St

15 Filed 1930. 19 RCK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to July 11, 1930,

that I last saw her alive on July 11, 1930,

and that death occurred, on the date stated above, at 6 00 A. m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

CONTRIBUTORY (Secondary): Secondary Anaemia and senile degeneration of Brain (duration) 1 yrs. mos. 3 ds.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none made

(Signed) Harry F Kates, M. D.

, 19 (Address) 523 Scott St. —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	July 14 1930
20 UNDERTAKER	ADDRESS
Harry H Duncan	1420 N Fulton Ave

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58714

CERTIFICATE OF DEATH

90 E 58714

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1013 S. Howard St. St.) 23-31 Ward)

2-FULL NAME Alice Brogden.(C)

(a) RESIDENCE NO. 1013 S. Howard St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, ~~widowed or divorced~~ (or) WIFE of John Brogden.(C)

6 DATE OF BIRTH (month, day, and year) January 3, 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	52	6	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Riggs.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Rachael Connor.C

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Carrie Brogden.(C) daughter.
(Address) 1013 S. Howard St.

15 Filed JUL 11 1930 19 H. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) H. M. Leinhardt, M. D.

7/9, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL 7/10/30.

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1349 N. Hamburg St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58715 37 E 58715

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (No. ..... St., M-7-7 WARD)

2-FULL NAME Eloise Gamble

(a) RESIDENCE NO. 1417 W. Mulberry st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Gamble

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Pinkney McFadden

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Margaret Dingle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records
(Address)

15 Filed JUL 1 1930 HAMPSON JONES, M. D. Registrar

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 2, 19 30, to July 10, 19 30, that I last saw her alive on July 10, 19 30, and that death occurred, on the date stated above, at 3.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

7-11, 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Hill Md.

DATE OF BURIAL 7/12/1930

ADDRESS

20 UNDERTAKER Mrs. Geo. H. Holland 1631 Druid Hill

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58716 (1)

REGISTERED NO. 197 E 58716

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST. 6-9 WARD)

2-FULL NAME Blanche Grenz

(a) RESIDENCE NO. 11 Irvin Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter A. Grenz

6 DATE OF BIRTH (month, day, and year) Sept 17/1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	9	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) Freeport,
(State or country) N.Y.

PARENTS

10 NAME OF FATHER Andrew Rhod es

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.Y.

12 MAIDEN NAME OF MOTHER Arabella Woods

13 BIRTHPLACE OF MOTHER (city or town) New York City
(State or country)

14 Informant Walter A. Grenz
(Address) 769 W. Lexington St.,

15 Filed JUL 17 1930 C. HAMPSON JONES, M.
Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage due to pistol shots of abdominal organs
(Homicide- Inquest to be held July 14/30)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [redacted], M. D.
Coroner

7/11/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL 7/11/30

20 UNDERTAKER [redacted] Wendell, D Wood ADDRESS 3305 Eden

ATTENTION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

E 58717

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58717

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE, (No.) 330 S. Bentalou St (WARD) 19-A

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E Rider

(Residence in Baltimore: No. 330 S. Bentalou St St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May (Month) 9 (Day), 1929 (Year)

7-AGE, 1 yrs. 2 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John E Rider

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ida Rice

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. John E Rider
(Address) 330 S. Bentalou St.

15- JUL 12 1930 E. HAMPSON JONES, M. D. 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 10 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1930, to July 10 1930; that I saw him alive on July 10 1930; and that death occurred, on the date stated above, at 8 45 a.m.

The CAUSE OF DEATH* was as follows:
Acute Ileocolitis
(Duration) ....yrs. ....mos. 2 ds.
CONTRIBUTORY (Secondary) Acute Myocarditis
Pulmonary Edema (Duration) ....yrs. ....mos. 1 ds.

(Signed) Norbert C Hutsch M. D.
July 10, 1930 (Address) 2151 Woltman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL. 7-12-30

20-UNDERTAKER Harry Stritzke ADDRESS Edmondson Ave

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E.58718 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 A 58718

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (No.....ST., 18-16 WARD)

2-FULL NAME Margaret King

(a) RESIDENCE NO. 424 N. Poppleton st. ST., ...WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
17	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Herman King

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Bertha ?

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed JUL 12 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to July 10, 1930,

that I last saw her alive on July 10, 1930,

and that death occurred, on the date stated above, at 7.35 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

7-11 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 7-12 1930

20 UNDERTAKER Diamond Easton

ADDRESS 716 Park ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58719

CERTIFICATE OF DEATH

E 58719

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 912 St Barnabas St. (If not in Baltimore give county) Ward 17-24

2-FULL NAME Annie Johnson

(a) RESIDENCE NO. 912 St Barnabas St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wallace —

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis
(State or country) Md.

PARENTS

10 NAME OF FATHER Moses Johnson

11 BIRTHPLACE OF FATHER (city or town) A A Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Annie Cox

13 BIRTHPLACE OF MOTHER (city or town) A A Co
(State or country) Md

14 Informant Virginia Williams
(Address) 912 St Barnabas St

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

L 1 2 1930

Ref

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ethmoiditis Pig foot & Sausage

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H Leech, M. D.

July 11th (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL 7-12 1930

20 UNDERTAKER Dennis Gordon

ADDRESS 916 E Lanvale

OF DEATH in plain terms, so that it may be properly classified. Date statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58720

CERTIFICATE OF DEATH.

91 302

E 58720

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3121 Clifton Av. St. 6-40 Ward)

2-FULL NAME Mrs. Maria C. Bergemer

(a) RESIDENCE NO. 3121 Clifton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marriott A. Bergemer

6 DATE OF BIRTH (month, day, and year): June 14 1857

7 AGE: Years 73 Months Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jacob Rottberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wilbur J. Bergemer

(Address) 3121 Clifton Ave

15 Filed 12 1930, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/1/30 19

17 I HEREBY CERTIFY, That I attended deceased from January, 1930, to July 1, 1930, that I last saw h alive on July 1, 1930, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Basham & Graf M. D.

7/1, 1930 (Address) Cranley 8

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: July 12, 1930

20 UNDERTAKER: Koepfle & Cook

ADDRESS: 1003 W Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 58721

CERTIFICATE OF DEATH

E 58721

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2924 Bernard ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Josephine B. Goodwin

(a) RESIDENCE NO. 2924 Bernard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	Wh.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank P. Goodwin

6 DATE OF BIRTH (month, day, and year) Dec. 9/1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	77	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Jno. Boden

11 BIRTHPLACE OF FATHER (city or town) Balto Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Gorsuch

13 BIRTHPLACE OF MOTHER (city or town) Balto Co.
(State or country) Md

14 Informant Mrs Martha Wantley

(Address) 2924 Bernard St.

Filed JUL 12 1930, 19 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11/30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1929, to July 11 1930, that I last saw h.. alive on July 11 1930 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Senility & Cerebral
Arterio sclerosis
Feeble mind

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Weakening cardiac ability & Bed sores

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. A. Smith M. D.

7/11, 1930 (Address) 1605 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	July 14 1930

20 UNDERTAKER Kerrigan & Doyle ADDRESS 1723 N. Lafayette Ave

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

E 58722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 58722

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 N. Bouldin St. 96-11 Ward)

2-FULL NAME Augusta Wiethege

(a) RESIDENCE NO. 409 N. Bouldin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (~~HUSBAND of~~ or) WIFE of Henry F. Wiethege

6 DATE OF BIRTH (month, day, and year) Feb-18-1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Benjamin Evans

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Liza Bevans

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Henry F Wiethege (Address) 409 N Bouldin St

15 Filed 12 1930 19 Reg. ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10/30

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to July 10, 1930,

that I last saw h[er] alive on July 10, 1930,

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma - of Uterus

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 14/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Philbert Arligiani M. D.

19 (Address) 2942 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dist Comml Cemetery

DATE OF BURIAL July 14 1930

UNDERTAKER Jno E Miller & Son

ADDRESS Baltimore

G. HARRISON JONES, M.

Spec.—1-30—M. & T.—250 Blks.

E 58723

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University of Maryland Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST. 4-30 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Contee

(a) RESIDENCE NO. Edenton, Md. ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905, Dec 23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	6	17 16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework, maid.

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer Mrs. A. D. Riden

9 BIRTHPLACE (city or town) Edenton, Md.
(State or country)

PARENTS

10 NAME OF FATHER William Contee

11 BIRTHPLACE OF FATHER (city or town) Edenton Md.
(State or country)

12 MAIDEN NAME OF MOTHER Eliza Thomas

13 BIRTHPLACE OF MOTHER (city or town) Edenton, Md.
(State or country)

14 Informant V. L. Fladung
(Address) HAMPSON JONES, M.

15 Filed 1-2 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9th, 1930.

17 I HEREBY CERTIFY, That I attended deceased from 9 A.M. July 9th, 1930, to 4:35 July 9, 1930, that I last saw h.e.r. alive on July 9, 1930, and that death occurred, on the date stated above, at 4.35 P.m.

The CAUSE OF DEATH* was as follows:

Anaemia, secondary, Vincent's angina.
Otitis media, suppurative acute
Syphilis, tertiary.
chronic, unknown (duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Vincent's angina; anemia.
Chronic, unknown (duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Edenton, Md.

Did an operation precede death? No Date of _____

Was there an autopsy? Yes.

What test confirmed diagnosis? Wassermann 4-4; Blood count; Culture from vincent M

(Signed) R. C. Hudson. M. D.

, 19 (Address) University of Maryland Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebon A & C Co Md

DATE OF BURIAL July 12 1930

UNDERTAKER D. M. Fladungtons

ADDRESS Bowie Md

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58724

E 58724

CERTIFICATE OF DEATH

49

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 N Caroline ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Johnsen

(a) RESIDENCE NO. 1023 N Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
f	C	Married

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rupert Johnsen

(Address) 1023 N Caroline St

15 Filed JUL 12 1930 Registrar C. HAMPSON JOHNS, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1930

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1930, to July 9, 1930

that I last saw her alive on July 9, 1930

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cyclitis Subacute

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George S Allen M. D.

July 9, 1930 (Address) 5 E Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cemetery	July 12 1930
20 UNDERTAKER Mrs B A Elliott	ADDRESS 1735 Ashland Ave

Spec.—1-30—M. & T.—250 Blks

E 58725 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58725

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 24-37 ST.) WARD)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irvin Meyer

(a) RESIDENCE NO. 400 Chestnut St. (Reading, Pa ST.) WARD W. Reading, Pa.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) July 2, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tool maker 031

(b) General nature of Industry, business, or establishment in which employed (or employer) Textile Machine C

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Irvin Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Winford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of (Address) Balto. City Hospitals

15 Filed 7 2 1930 C. HERMAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-10-30

17 I HEREBY CERTIFY, That I attended deceased from 7-6-30, 19..., to 7-10-30, 19..., that I last saw him alive on 7-10-30, 19..., and that death occurred, on the date stated above, at 4:35 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, lobar

(duration) ...yrs. ...mos 6 ds.

CONTRIBUTORY (Secondary) None

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Podgel, M. D.

7/2, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reading Pa

DATE OF BURIAL 7/2 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 Park St

Spec.—2-29-28—L. F. S.—500 Bks.

E 58726 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58726

CERTIFICATE OF DEATH

REGISTERED NO. 161

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Milton Waters

(a) RESIDENCE NO. 2209 Cecil ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Waters

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Loretta Marguil Moylan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant William Waters

(Address) 2209 Cecil ave.

15 Filed JUL 12 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1930, to July 11, 1930, that I last saw him alive on July 11, 1930 and that death occurred, on the date stated above, at 11 25 P.m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Rudolph L. Schorke, M. D.

7/12, 1930 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	July 12 1930
20 UNDERTAKER Harry Sloes Sons Inc.	ADDRESS 1301 E Eager St

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

58727

CERTIFICATE OF DEATH.

X 45 E 58727

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital 12-49 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Hastings

(a) RESIDENCE NO. Snow Hill Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Scott Hastings

6 DATE OF BIRTH (month, day, and year) July 31, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	11	13	17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired merchant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Westchester Md.
(State or country)

PARENTS

10 NAME OF FATHER Lawrence Hastings

11 BIRTHPLACE OF FATHER (city or town) Westchester Md
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Bowen

13 BIRTHPLACE OF MOTHER (city or town) Westchester Md
(State or country)

14 Informant Hospital Records
(Address)

15 Filed JUL 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 3rd, 1930, to July 13th, 1930, that I last saw h/m alive on July 12th, 1930, and that death occurred, on the date stated above, at 4-30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 10th 1930

Was there an autopsy? No

What test confirmed diagnosis? X-ray & operation

(Signed) Samuel McCausland, M. D.

July 13 1930 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salisbury Md

DATE OF BURIAL July 13 1930

20 UNDERTAKER Henry Perkins & Co

ADDRESS Baltimore Md

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58728

CERTIFICATE OF DEATH.

166

E 58728

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Balt. Gen. Hosp.

CITY OF BALTIMORE: (No.) Raynor & Dukeland St. 30-64 (Ward)

2-FULL NAME Mrs. Dora Muffoletta.

(a) RESIDENCE NO. 2421 Calverton Hts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Anthony Muffoletto

6 DATE OF BIRTH (month, day, and year): April 2, 1900

7 AGE: Years 30; Months 3; Days 9; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Lawrence Vozzana

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rosalie Mazzone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Rosario Glorioso

(Address) 392 Calverton Hts

15 Filed 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11 1930

17

I HEREBY CERTIFY, That I attended deceased from July 4, 1930, to July 11, 1930, that I last saw her alive on July 11, 1930, and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis following Erysipelas possibly

(duration) yrs. mos 7 ds

CONTRIBUTORY (Secondary) uremia

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

What was autopsy?

What test confirmed diagnosis?

Signed E. C. De Marco, M. D.

19 (Address) Interne Westbalt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: July 14 1930

20 UNDERTAKER: Frank V. Pepitone

ADDRESS 2918 E. Balto

ATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58729

CERTIFICATE OF DEATH

38 E 58729

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 522 W Preston St., (Ward) 17-26

2-FULL NAME Viola Smothers

(a) RESIDENCE NO. 522 W. Preston St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Jennie Douglas
(Address) 522 W. Preston

15 Filed ..... 1930 H. HANSON JONES, M. D. Registrar
JUL 13 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Syphilis.

(duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Negative
(Signed) July 10 [illegible], M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL July 13 1930

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58730

CERTIFICATE OF DEATH

E 58730

1735

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. West Balto Gen Hosp St.) (Ward) 17-55

2-FULL NAME Tonie Dantoni

(a) RESIDENCE NO. 5410 Parkheights St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Dantoni

6 DATE OF BIRTH (month, day, and year) Dec 2 1887

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	42	7	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Tonie Dantoni

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Rose Lasagna

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Catherine Dantoni
(Address) 637 Cookman

15 Filed ..... 19.. Registrar

JUL 3 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide
Fractured Skull &
Crushed both Legs.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Threw himself under Electric Car

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Parkheights & Rendall

Did an operation precede death? NO Date of .....

Was there an autopsy? NO

What test confirmed diagnosis? Regular

(Signed) H. L. Fink, M. D.

(Address) Bowers

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 7/14 1930

20 UNDERTAKER Kirk & Brooks & Son

ADDRESS Baltimore Md

IMPORTANT. See instructions on back of certificate. OF DEATH in plain terms, so that it may be a property classified. Exact statement of occupation is very

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58731

E 58731

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 E Fort Ave ST., 24-35 WARD)

2-FULL NAME Thomas J. Little

(a) RESIDENCE NO. 1504 E Fort Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fuller Summerlin

6 DATE OF BIRTH (month, day, and year) July 27 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64	65	11	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Petersburg Va.

PARENTS

10 NAME OF FATHER Thomas J Little

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Miller Little
(Address) 1504 E Fort Ave.

15 Filed JUL 13 1930, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to 7/10, 1930, that I last saw him alive on 7/9, 1930, and that death occurred, on the date stated above, at 8 45 P.m.

The CAUSE OF DEATH* was as follows:
Gastric Carcinoma

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? none.

(Signed) Dan Chandler, M. D.
7/14, 1930 (Address) 122 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem
DATE OF BURIAL July 14 1930

20 UNDERTAKER Chas. P. Sterne
ADDRESS 1301 E Fort Ave

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

58732 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58732

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Univ Hosp.

CITY OF BALTIMORE: (No. ST., 7-13 WARD)

2-FULL NAME Eva Garber

(a) RESIDENCE NO. 2517 19th Ave North ST., Minneapolis Minn. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	married

5a If married, widowed or divorced HUSBAND of or) WIFE of Samuel Gerber

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Brenski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bendem

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Abraham Lewis

(Address) 1439 E. Baltimore St

15 Filed JUL 13 1930 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12-30

17 I HEREBY CERTIFY, That I attended deceased from 7-10, 1930, to 7-12, 1930, that I last saw h. alive on 7-12, 1930, and that death occurred, on the date stated above, at 8 30 a.m. EST.

The CAUSE OF DEATH* was as follows:

Chr. lymphatic leukemia

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Chr. myocarditis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Exam.

(Signed) Milton B. Kirst, M. D.

7/17 1930 (Address) Univ Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Minneapolis Minnesota

DATE OF BURIAL 7/13 1930

20 UNDERTAKER Jacob Lewis 1439 E Baltimore St

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 58733

E 58733 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3719 Parkheights Ave. (WARD) 58

2-FULL NAME Esther Marks

(a) RESIDENCE NO. 3719 Parkheights Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced (or) WIFE of HUSBAND of Harris Marks

6 DATE OF BIRTH (month, day, and year)	Months	Days	If LESS than 1 day, ...hrs. or ....min.
7 AGE 83	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Gustave

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dorkam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Albert Marks (Address) 2519 Kenderton Ave

15 Filed ... 19... Per ... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11-30

17 I HEREBY CERTIFY, That I attended deceased from 7/10/30, 19..., to 7/11/30, 19..., that I last saw her alive on 7/11/30, 19..., and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypertension

Uremia

(duration) years yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Meyer Muller, M. D.

7/11, 1930 (Address) 3649 Park Hts Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrent Remidelat DATE OF BURIAL July 13 1930

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eutaw St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 58734 **E 58734**

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 639 Pitcher St. WARD) 11-20

2—FULL NAME Lillian E. Jackson

(a) RESIDENCE NO. 639 Pitcher ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eugene Jackson

6 DATE OF BIRTH (month, day, and year): Dec 5, 1898

7 AGE: Years 33 | Months ~~11~~ 6 | Days ~~25~~ 26 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Fredrick Md

PARENTS

10 NAME OF FATHER: John Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Celia Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Helig Ordway (Address): 639 Pitcher St

15 Filed JUL 13 1930 CITY HALL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1930, to July 11, 1930, that I last saw h[illegible] alive on July 11, 1930, and that death occurred, on the date stated above, at 10.25 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem | DATE OF BURIAL: 7-13 1930

20 UNDERTAKER: Lotte & Irvin | ADDRESS: [illegible] Ashland ave

Important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58735

E 58735

CERTIFICATE OF DEATH

REGISTERED NO. 159-007

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Coleman

(a) RESIDENCE NO 1208 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 24/30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Richard Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Henrietta Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Richard Coleman
(Address) 1208 E. Madison St

15 Filed ....., 192 THOMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bilateral Lobular Pneumonia
Lung Abcesses.
Patent Foramen Ovale

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? at Hopkins

What test confirmed diagnosis?

(Signed) [signature] Coroner, M. D.

7/12/30 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leisburg Penn — DATE OF BURIAL 7-13 1930

20 UNDERTAKER Jas. M. Skinner — ADDRESS [illegible]

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58736

CERTIFICATE OF DEATH.

129 ✓

E 58736

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1627 Druid Hill ST. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. Newton

(a) RESIDENCE NO. 1627 Druid Hill ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene Newton

6 DATE OF BIRTH (month, day, and year) June 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) N. L. Edmand

(c) Name of employer & Bro

9 BIRTHPLACE (city or town) (State or country) Chas Co Md

PARENTS

10 NAME OF FATHER John Newton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md Maryland

12 MAIDEN NAME OF MOTHER Mary Newton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Annabelle Newton

(Address) 1627 Druid Hill Ave

15 Filed 19 C. HARRY JONES, M. D. Registrar

L 13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/12 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/1 1930 to 7/12 1930, that I last saw h alive on 7/11 1930 and that death occurred, on the date stated above, at 6 A m

The CAUSE OF DEATH* was as follows:

Chr. Nephritis X

Aortic Incompetency

(duration) yrs. 4 mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. R. Newton M. D.

7/13 1930 (Address) 2139 O St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 7/15 1930

UNDERTAKER Daniel F. Hennelly

ADDRESS 678 N Bond

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 58737.

CERTIFICATE OF DEATH.

31 E 58737

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2568 W.Baltimore ST. 70-69 WARD)

2-FULL NAME Minnie A. Fanshaw

(a) RESIDENCE NO. 2568 W.Baltimore ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 10 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph Fanshaw

6 DATE OF BIRTH (month, day, and year) 8-13-1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles H.Albiker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Emma Albrecht

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore.

14 Informant (Address) Joseph Fanshaw 2568 Balto. St.

15 Filed OCT 13 1930 Registrar C. HARRISON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1930

17 I HEREBY CERTIFY, That I attended deceased from June 15th. 1930, to July 12th. 1930, that I last saw her alive on July 12th. 1930, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis with Auricular fibrilation.

(duration) Don't know yrs. mo. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. H. Duvall, M. D.

, 19 (Address) 1817 N.Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

UNDERTAKER E.D. Wiepert. ADDRESS 1850 N. Balto St

DATE OF BURIAL 7/14/30

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58738

CERTIFICATE OF DEATH

185 ✓

E 58738

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital 20-69 St., Ward)

2-FULL NAME Adam Kempf

(a) RESIDENCE NO. 4335 S. Smallwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine Kempf

6 DATE OF BIRTH (month, day, and year) June 27-1865

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	65	0	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Swift & Co.

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Kempf

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Serfest

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant (Address) Catherine Kempf 4335 S. Smallwood St

15 Filed ..... 19.... Registrar

JUL 13 1930 C. HAROLD JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull. Accidental Death. Fell from platform at work

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured ribs,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Swift & Co.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Gelbert M. D.

7/12. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK CEMETERY	7/14/1930

20 UNDERTAKER G. A. Klupfel 1850 N. Bellaire ADDRESS

Spec. 6-9-19—H. P. Co.—1000 Bks.

58739

HEALTH DEPARTMENT—CITY OF BALTIMORE

29-001

E 58739

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 W. Hamburg St. 21-24 WARD)

2-FULL NAME Howard A. Seitz

(a) RESIDENCE. NO. 732 W. Hamburg St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30-1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER Howard A. Seitz

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Geneva Morris

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Howard A. Seitz
(Address) 732 W. Hamburg St

15 Filed JUL 13 1930 19 HAMPSON JONES, M. D. Registrar

RPK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to July 11, 1930, that I last saw h[illegible] alive on July 11, 1930, and that death occurred, on the date stated above, at 11.45 m.

The CAUSE OF DEATH* was as follows:

Tetanus (Acute) resulting from injury caused by Explosion of blank Cartridge on July 4/30 (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) J. M. Dilworth, M. D.

July 11 1930 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL July 14-30 19

20 UNDERTAKER Franklin W. Seitz ADDRESS 709 W 33rd St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58740

REGISTERED NO. 31 E 58740

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 W. Biddle St. 11-24 WARD)

2-FULL NAME Helen R. Smith

(a) RESIDENCE NO. 211 W. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Smith

6 DATE OF BIRTH (month, day, and year): Oct. 8 - 1909

7 AGE: Years 20 | Months 9 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Samuel Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mary Richardson 211 W. Biddle St

15 Filed July 13 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11 1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to July 11, 1930, that I last saw h[er] alive on July 11, 1930, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

Duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Garland Whitfield, M. D.

July 12 1930 (Address) 1354 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westover, Md.

DATE OF BURIAL: 7/14/1930

UNDERTAKER: Jas. Geo. H. Hollan

ADDRESS: 1631 Druid Hill Ave

FROM EVERY important See instructions on back of Certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 58741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 58741

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 7-25 Ward)

2-FULL NAME Herman Jones

(a) RESIDENCE NO. 535 Penna. Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Pearl Jones

6 DATE OF BIRTH (month, day and year): March 1892

7 AGE: Years 38 | Months 3 | Days 24 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kent Co
(State or country) Md.

PARENTS

10 NAME OF FATHER John Ford

11 BIRTHPLACE OF FATHER (city or town) Kent Co
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) Kent Co
(State or country)

14 Informant Mary Parsons
(Address) 535 Penna Ave

15 Filed....., 19..... Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. few hours

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 535 Penna Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. Schmuck, M. D.

July 11 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 7-14 1930

20 UNDERTAKER: Dennis Eaton — ADDRESS 916 Pine

OF DEATH in plain terms, so that it may be properly classified. Make statement of occupation specific. important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58742 CERTIFICATE OF DEATH. X 124 E 58742

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton + Wilkens Aves (St.) 95-12 (WARD)

2-FULL NAME James Checo

(a) RESIDENCE NO. Delta, Pa. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 11 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
50				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Europe

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Adam Checo
(Address) Delta Pa

15 Filed JUL 19 1930 C. HAWLEY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-13 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-2, 1930, to 7-13, 1930, that I last saw him alive on 7-13, 1930, and that death occurred, on the date stated above, at 6 30 a.m. E Standard Time

The CAUSE OF DEATH* was as follows:

Cholecystitis Chronic - c

Acute dilatation of Stmach - 8 wks. (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) P.O. Pneumonia (duration) yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 7-11-30

Was there an autopsy? Yes

What test confirmed diagnosis? Frozen Section

(Signed) Hy Omar S. Anderson M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delta Pa

DATE OF BURIAL 7/15 1930

20 UNDERTAKER H. P. Harkins.

ADDRESS Delta Pa

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-00 E 58743

CERTIFICATE OF DEATH.

58743

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor St. 16-14 WARD)

2-FULL NAME Mariana Pratt

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edwin Pratt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Elz. Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor (Address) Preston & Valley St.

15 Filed JUL 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 11, 1930, that I last saw h alive on July 11, 1930, and that death occurred, on the date stated above, at 12 30 a. m.

The CAUSE OF DEATH* was as follows:

a Senility

Arteriosclerosis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D Bernard Lurh M. D.

7/13 1930 (Address) 1246 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL 7/14 1930

20 UNDERTAKER P. J. Medefelt & Co

ADDRESS Fremont

Spec.—1-30—M. & T.—250 Bks.

E 58744

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58744

CERTIFICATE OF DEATH.

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2519 Harrison Blvd ST. 15-61 WARD

2-FULL NAME Mary Frances Dunnock

(a) RESIDENCE NO. 2519 Harrison Blvd ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Levin T. Dunnock.

6 DATE OF BIRTH (month, day, and year) Feb. 23, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co. (State or country) Md.

PARENTS

10 NAME OF FATHER John Langrall

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Priscilla Elizabeth Stewart

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mr. John L. Dunnock (Address) 2519 Harrison Blvd.

Filed JUL 14 1930 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1930

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to July 12, 1930, that I last saw h[illegible] alive on July 12, 1930, and that death occurred, on the date stated above, at 4 P.m. Day Sav.

The CAUSE OF DEATH* was as follows:

[illegible] pneumonia (Broncho) about 4 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia about 4 weeks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter S. Gilbert, M. D.

July 12 1930 (Address) 2225 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery DATE OF BURIAL July 15 1930

20 UNDERTAKER [illegible] Dickinson Bond ADDRESS Norfolk Va

Spec.—1-30—M. & T.—250 Bks

E 58745

E 58745 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Gough ST. 3-4 (WARD)

2-FULL NAME Bell Walbert

(a) RESIDENCE NO. 1407 Gough ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia (State or country)

PARENTS

10 NAME OF FATHER Abe Goldtzer

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Mrs. A. Levy (Address) 619 S. Broadway

15 Filed July 14 1930 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1925, to June 26, 1930, that I last saw her alive on June 26, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic myocardial fibrosis

Chronic nephritis arteriosclerosis (duration) 5 yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical. Lab.

(Signed) R. A. Michelson, M. D.

July 13, 1930 (Address) 2230 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave

UNDERTAKER Sol Levinson & Bro

DATE OF BURIAL July 14 1930

ADDRESS 117 E Balto St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58746

E 58746

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 S. Kenwood Ave. ST., 173 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L. Stockett

(a) RESIDENCE NO. 508 S. Kenwood Ave. ST., / WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Stockett

6 DATE OF BIRTH (month, day, and year) Dec. 16, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired City Employee.

(b) General nature of industry, business, or establishment in which employed (or employer) School Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Mary E. Stockett (Wife)

(Address) 508 S. Kenwood Ave.

15 Filed JUL 14 1930 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 11, 1930, that I last saw h im alive on July 11, 1930, and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

7/12 30. (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery.

DATE OF BURIAL July 14 1930.

20 UNDERTAKER Lilly & Zeiler, Inc.

ADDRESS 403 S. Wolfe St.

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58747

CERTIFICATE OF DEATH

E 58747

REGISTERED NO. 118-002

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Provident Hosp. St. 15-23 (Ward)

2-FULL NAME Joseph Daly

(a) RESIDENCE NO. 1327 Woodyear St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) June 11-1925

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	5	6	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Da Daly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Alice Jessup

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Da Daly
(Address) 1327 Woodyear

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) H. Feldman, M. D.

July 11 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 7-14 1930

20 UNDERTAKER Dennis Eaton

ADDRESS 576 Gay ave.

JUL 14 1930 HAMILTON JONES, M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58748

E 58748

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1129 Woodyear St., 16-23 Ward)

2-FULL NAME Wallace L Johnson

(a) RESIDENCE NO. 1129 Woodyear St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	94			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) [illegible] (State or country)

PARENTS

10 NAME OF FATHER Jas Johnson

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Charlotte Swan

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Charlotte Johnson
(Address) 1129 Woodyear

15 Filed [illegible] 19 Registrar

JUL 14 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 2 c 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) [illegible] M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pt Auburn Cem	7-14 1930
20 UNDERTAKER	ADDRESS 916 Park Ave
Daniel Carson	

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

3002 Harrison Blvd

E 58749

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58749

74-001

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Poplar Grove St.) (WARD) 16-67

2-FULL NAME James H. Valentine

(a) RESIDENCE NO. 1604 Poplar Grove St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma A. Valentine

6 DATE OF BIRTH (month, day, and year) Aug 18, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Wm. Martin

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Emma A. Valentine
(Address) 1604 Poplar Grove

15 Filed ....., 19.... By ..... Registrar

C. HAMPSON JONES, M.

14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1928, to July 11, 1930,
that I last saw h[illegible] alive on July 11, 1930,
and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) acute Nephritis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? +

(Signed) Geo W Kemmeter, M. D.

July 13, 1930 (Address) 3002 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 14, 1930

UNDERTAKER William Cook — ADDRESS 1217 St Paul

Spec.—1-30—M. & T.—250 Blks

E 58750 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 58750

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 642 E 29th ST., 9-46 WARD)

2-FULL NAME Edith C. Leach.

(a) RESIDENCE NO. 642 E 29th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 19, 1898

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31.	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Thomas J Leach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Agnes Sigmaff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs C Hooper

(Address) 29th Beechtree

15 1-4-1930 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Jan 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 14th, 19 30, to Jan 14th, 19 30

that I last saw him alive on Jan 14th, 19 30

and that death occurred, on the date stated above, at 5-0 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Myocarditis

(duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary) Acute Articular Rheumatism

(duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What tests confirmed diagnosis? Laboratory Examination

(Signed) Geo Hunzinger M.D.

Address 1451 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 1/16 1930

20 UNDERTAKER Penn Cook

ADDRESS 721 St Paul

Spec.—1-30—M. & T.—250 Blks.

E 58751

E 58751

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1. PLACE OF DEATH
CITY OF BALTIMORE: (NO.) South Baltimore Gen ST. (OR WARD) 1305 W Pratt
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Howard White

(a) RESIDENCE NO. 517 Annabelle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (01) HUSBAND of (01) WIFE of Ella M White

6 DATE OF BIRTH (month, day, and year) Jan 23 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman at 1086
(b) General nature of industry, business, or establishment in which employed (or employer) Varnish & Chem Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS
10 NAME OF FATHER Barney a White
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore
12 MAIDEN NAME OF MOTHER Emma A Travers
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Ella M White
(Address) 517 Annabel Ave

15 7-1-1930 Filed ..... 19 ..... Registrar

7-1-1930 H. JON JONES M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12-30

17 I HEREBY CERTIFY, That I attended deceased from 6-23-30, 19..., to 7-12, 1930, that I last saw him alive on 7-12, 1930, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary) Chronic Nephritis, (duration) yrs. 4 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Fistula 6-24-30 2 mo

Was there an autopsy?

What test confirmed diagnosis? Physical Signs

(Signed) Joseph L. Lankaitis, M. D.

, 19 (Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL July 15 1930

20 UNDERTAKER John F Denny — ADDRESS 715 Lig St

Spec.—2-29-28—L. F. S.—500 Bks.

E 58752

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58752

CERTIFICATE OF DEATH Hamilton 90

REGISTERED NO. 27-43

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5608 Fair Oaks Ave WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Lewis Corkran

(a) RESIDENCE NO. 5608 Fair Oaks Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Corkran

6 DATE OF BIRTH (month, day, and year): July 18 1857

7 AGE: Years 72 | Months 11 | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dorchester Co Md

PARENTS

10 NAME OF FATHER: James Corkran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dorchester Co Md

12 MAIDEN NAME OF MOTHER: Henrietta Lloyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Mary Corkran (Address) 5608 Fair Oaks Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10 1930

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1930 to July 10, 1930

that I last saw him alive on July 9 1930 and that death occurred, on the date stated above, at 11:10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) Several years

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) many years

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

7/12 1930 Address, Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood — DATE OF BURIAL: July 14 1930

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58753

E 58753

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2810 Grindon Ave ST., 27-44 WARD)

2-FULL NAME Amos F. Little

(a) RESIDENCE NO. 2810 Grindon ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie R. Little

6 DATE OF BIRTH (month, day, and year): May 1st 1861

7 AGE: Years 69; Months 2; Days 11; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: Samuel Little

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Annie R. Little

(Address) 2810 Grindon ave

15 Filed 1-4 1930 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1930

17 I HEREBY CERTIFY, that I attended deceased from June 1st, 1928, to July 12, 1930, that I last saw him alive on July 11th, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. L. Grady M. D.

7-13, 1930 (Address) Harford & Overlook Aves.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: July 15 1930

20 UNDERTAKER: Frederick Lasch Mortuary — ADDRESS: Fullerton

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58754

E 58754

CERTIFICATE OF DEATH.

REGISTERED NO. 124

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) St Agnes Hospital ST. 7-69 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Stair

(a) RESIDENCE NO. 30 S. Smallwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-10-30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John M. Stair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Bauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) St. Agnes Hospital

15 Filed 7 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-13 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-10, 1930, to 7-13, 1930, that I last saw him alive on 7-13, 1930, and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:

Hepatic hemorrhage rupturing through capsule of liver to bowel & thence peritoneum

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy M. D.

(Signed) Max Fields

7/13, 1930 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 7/14/1930

20 UNDERTAKER J. J. Moran

ADDRESS 3000 E. Baltimore

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58755

CERTIFICATE OF DEATH

129

E 58755

REGISTERED NO. 15-68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1301 Morland Ave. ST. 15-68 WARD

2—FULL NAME Louis A. Langzon

(a) RESIDENCE NO. 1301 Morland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bridget Fogarty Langzon

6 DATE OF BIRTH (month, day, and year) Feb. 4, 1858

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
72	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Malta Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mr. Louis Langzon

(Address) 1301 Morland Ave.

15 Filed ..... 19 ... HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/12/30

17 I HEREBY CERTIFY, That I attended deceased from 7/10, 1930, to 7/12, 1930, that I last saw h.... alive on 7/12, 1930 and that death occurred, on the date stated above, at 5 a, m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency

Hypertrophy & Dilated Chronic Interstitial Nephritis (duration) Years mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis Pulmonary Oedema (duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History & Phys. Exam.

(Signed) J. F. Duncan, M. D.

7/12 1930 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL July 15, 1930.

20 UNDERTAKER Martin Baker & Sons

ADDRESS 1827 N. Howard

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58756

CERTIFICATE OF DEATH

REGISTERED NO. 90 E 58756

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 58[illegible]

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital St. 14-27 Ward)

2-FULL NAME Charles H Neal

(a) RESIDENCE NO. 411 N Parrish St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	about 49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer Balto City

9 BIRTHPLACE (city or town) Balto City (State or country)

PARENTS

10 NAME OF FATHER John Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachael Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) James F Neal 1104 Druid Hill Ave

15 Filed [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis with Cardiac Insufficiency

(duration) ...yrs. 1 mos. ...ds.

CONTRIBUTORY (Secondary) unknown

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James H Hunton M. D.

7/10/1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL July 12, 30

20 UNDERTAKER Thomas E Kelson — ADDRESS 1703 Presstman St

O. HAMPSON JONES, M. D.

IMPORTANT. See instructions on back of certificate. Use BLACK INK and write in plain terms, so that it may be properly examined. Erasures, interlineations or alterations will render certificate void. CERTIFICATE OF DEATH must be filed with the Registrar of the district in which death occurred before a burial permit can be issued.

Spec.—1-30—M. & T.—250 Bks

HARRON

E 58757 HEALTH DEPARTMENT—CITY OF BALTIMORE

38

E 58757

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS (WARD) 23-21

CITY OF BALTIMORE: (NO.

2-FULL NAME Frederick J. Harron.

(a) RESIDENCE NO. 921 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Harron.

6 DATE OF BIRTH (month, day, and year) December 10-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39-	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. NO

(b) General nature of industry, business, or establishment in which employed (or employer) Ship-yard

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Peter J. Harron.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records (Address) BALTIMORE CITY HOSPITALS

15 Filed Sep 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to July 12, 1930, that I last saw him alive on July 12, 1930, and that death occurred, on the date stated above, at 11:10 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Syph. is of central nervous System (duration) unknown. yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical. Wasserman.

(Signed) Paul Padget, M. D.

3 19 30 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL 7/16 19 30

UNDERTAKER Chas. H. Grandstaff ADDRESS 118 W. Mt. Royal Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58758

182 E 58758

CERTIFICATE OF DEATH

E 58758

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH (No.) Voss Falls Cedar en Bridge St., (Ward) 50

City of Baltimore:

2-FULL NAME Wm. F Dalcher

(a) RESIDENCE NO. 3205 Barclay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	C.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 15, 1930

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	5	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm Dalcher

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Emma McGinn

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Wm Dalcher
(Address) 3205 Barclay St.

15 Filed ... 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:* Acc Drowning (Swimming)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? July 30

What test confirmed diagnosis? Ex Inquest

(Signed) W. H. Hadley, M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL July 15 1930

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1725 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 58759 HEALTH DEPARTMENT—CITY OF BALTIMORE

78 ✓ E 58759

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1620 W Lexington St.) (WARD) 1927

2-FULL NAME Sylvia Williams

(a) RESIDENCE NO. 1620 W. Lexington ST., WARD _____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow

5a If married, widowed, or divorced HUSBAND) of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
about 80			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Maryland Baptist Home
(Address) 1620 W. Lexington St.

15 Filed 7-14 1930 S. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9-1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 9, 1930, that I last saw h[illegible] alive on July 9, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Epilepsy
(duration) three days yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. J. Barksdale, M. D.
7/14, 1930 (Address) 524 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL July 15 1930

20 UNDERTAKER Mrs. H. G. Elliott — ADDRESS 1725 Ashland Ave

Spec.—1-30—M. & T.—250 Blks.

E 58760 B 58760

23478760

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 54

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (NO. ..... ST., 7-9 WARD)

2-FULL NAME James W. Brown

(a) RESIDENCE NO. Springfield Tenn ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan-10-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tenn

PARENTS

10 NAME OF FATHER Jordan S Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn

12 MAIDEN NAME OF MOTHER Josephine Woodbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn

14 Informant Jordan S. Brown (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-13-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb-18, 1930, to July 13, 1930, that I last saw him alive on July 13, 1930 and that death occurred, on the date stated above, at 12 57 A.m.

The CAUSE OF DEATH* was as follows: Pellagra, G. I. atony, Gen. Colitis, Enteritis of Ileum & Right Lung Cav. ++

(duration) ..... yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) S. Hatzenelbogen, M. D.

July 16 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Springfield, Tenn.	July 16, 1930

UNDERTAKER John O. Mitchell & Sons ADDRESS 1900 Eastern Av.

Spec.—1-12-23—M&T—500 Bks.

E58761 HEALTH DEPARTMENT—CITY OF BALTIMORE E58761

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 706 Berry (St.) 21-29 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Tull

(a) RESIDENCE NO. 706 Berry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where dead Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sallie Tull

6 DATE OF BIRTH (month, day, and year): Aug 11-1851

7 AGE: Years 78 | Months 11 | Days 28 | If LESS than 1 day, ...hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Galeston Md

PARENTS

10 NAME OF FATHER: Andrew Tull

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Howard Tull

(Address) 706 Berry St

15 Registrar: C. HAMPSON JONES, M. D. Registrar

JUL 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1930

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to July 12, 1930, that I last saw h[illegible] alive on July 12, 1930, and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) Indefinite yrs. mos. da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. L. Campbell, M. D.

7/12 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pocomoke City Md — DATE OF BURIAL: July 15 1930

20 UNDERTAKER: Geo M. Dunn & Son — ADDRESS: 811 N Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 58762

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58762

129

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 888 N. Lombard St. ST., 18-29 WARD)

2—FULL NAME Catherine A. Norton,

(a) RESIDENCE NO. 888 N. Lombard St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White.	Widow.

5a If married, widowed, or divorced (or) WIFE of John C. Norton (Dicased.)

6 DATE OF BIRTH (month, day, and year) Dec. 17, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) none.

(c) Name of employer none.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Patrick St Leger.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Hannah Cusack.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Chas. Norton, (Address) 888 N. Lombard St.

15 Filed JUL 14 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12. 1930. to July 13. 1930.

that I last saw h[illegible] alive on July 13. 1930.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Atherosclerosis.

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Ad. Nephritis.

(duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Analysis, Etc

(Signed) Chas Norton, M. D.

7/13/30 (Address) 888 N. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL July 16 30

20 UNDERTAKER Fred A. Klauser.

ADDRESS 1 E Madison St

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58763

E 58763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital S. 13659 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Merfeld.

(a) RESIDENCE NO. 2227 Callow Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Isadore Merfeld.

6 DATE OF BIRTH (month, day, and year) Jan 18, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69	68 yrs.	6 5	5 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk Va.
(State or country)

PARENTS

10 NAME OF FATHER Josiah Boettigheimer

11 BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) Germany.
(State or country)

14 Informant Harry A. Merfeld

(Address) Fort Worth, Texas.

Filed JUL 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 1st. 1930, to July 14 1930,

that I last saw her alive on July 14, 1930,

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical findings.

(Signed) H. Boedeker, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Har Sinai Cemetery

DATE OF BURIAL 7/14/1930

20 UNDERTAKER Brand Soudheim & Son

ADDRESS 1902 Eutaw Place

TION IS Very Important. See INSTRUCTIONS ON BACK OF CERTIFICATE

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58764 × 84 E 58764

E 58764

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 7-9 WARD)

2-FULL NAME Edgar Bally

(a) RESIDENCE NO 337 E. Clay St., Lancaster St, Pa. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coach Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 050
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER John Bally

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Frances Zahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Hopkins Records

(Address)

15 Filed [illegible] 193[illegible] C. HAMPSON JONES, M. D., Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 13

Was there an autopsy? At Hopkins Hospital

What test confirmed diagnosis?

(Signed) J. C. H. Jones, M. D. Coroner

7/14/30 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster Pa

DATE OF BURIAL 7/15/30

20 UNDERTAKER Joseph Ahern's

ADDRESS 221 Rus

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58765

E 58765

CERTIFICATE OF DEATH

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospitals St. 7-72 Ward)

2-FULL NAME George Klaus

(a) RESIDENCE NO. 912 Pennsylvania St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Mal	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Klaus

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer) Himself
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Francis Klaus

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anne Kuck

13 BIRTHPLACE OF MOTHER (City or town)
(State or country) Germany

14 Informant Katie Klaus
(Address) 505 Park ave

15 Filed ..... C. HARRISON JONES, M. D.
Registrar

L 14 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Exo death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Arterio-Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

7/13 1930 (Address) 7001 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 7/15 1930

20 UNDERTAKER Edward Foulkrod

ADDRESS 2309 West North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58766 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58766

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) University Hospital ST., 4-30 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Kruithoff (KRUITHOFF)

(a) RESIDENCE NO. 7020 Belclare Rd ST., WARD Dundalk
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. 9 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed or divorced HUSBAND of or) WIFE of Emily Kruithoff

6 DATE OF BIRTH (month, day, and year) May 6, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	2	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) (Clerk Retired)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Louise Thompson
(Address) 7020 Belclare Road Dundalk

15 Filed 1-4 1930 C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1930 to July 13, 1930.
that I last saw him alive on July 13, 1930,
and that death occurred, on the date stated above, at 11:25 P. m.

The CAUSE OF DEATH[a] was as follows:
(Ruptured appendix)
Appendicitis
(duration) yrs. mos 8 ds.
CONTRIBUTORY (Secondary) Peritonitis; pulmonary edema (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? yes Date of July 9, 1930
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) George H Yeager M. D.
July 13 1930 (Address) University Hospital

[a]State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn N. Y. DATE OF BURIAL July 15, 1930

20 UNDERTAKER Wm. J. Fichter & Son ADDRESS North & Pa

Spec.—1-30—M. & T.—250 Blks.

238678
E 58767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 58767

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE, (No.) Sophia St. 12-49 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelia Wright

(a) RESIDENCE NO. 403 Southway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Charles Willis Wright

6 DATE OF BIRTH (month, day, and year) Nov 15 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	7	28.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Albert A Stockley

11 BIRTHPLACE OF FATHER (city or town) New York (State or country) U.S.

12 MAIDEN NAME OF MOTHER Amelia Schilliger

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records Johns Hopkins Hospital (Address)

15 Filed 1930 By C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-13-1930

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1930, to July 13, 1930, that I last saw her alive on July 13, 1930, and that death occurred, on the date stated above, at 4:13 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Carcinoma & Thyroid

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of July 11. 30

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Thomas B. Futcher, M. D.

VII 13, 1930 (Address) 1201 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL July 16 1930

UNDERTAKER Wm Tuckner ADDRESS Govt Notch Pa

Spec.—1-30—M. & T.—250 Bks.

E 58768 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58768

CERTIFICATE OF DEATH.

REGISTERED NO. 65

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1639 W. North Ave ST., 15-21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Schumacher

(a) RESIDENCE NO. 1639 W. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 25, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jos. Schumacher Balto. Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Jos. Schumacher

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary A. Markland

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Miss Elizabeth Schumacher (Address) 1639 W. North Ave

15 Filed JUL 14 1930, 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 12, 1930, that I last saw h[illegible] alive on July 12, 1930, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Thos. K. Freeman M. D.

7/14, 1930 (Address) 807 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL July 15, 1930

20 UNDERTAKER Wm. Hickey & Sons ADDRESS North & Pa

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58769 ✓

E 58769

CERTIFICATE OF DEATH.

× 51

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital ST. 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Jeanne Cox

(a) RESIDENCE NO. 319 S. Union Ave. Havre de Grace Md. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
White	female	—

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14 1925

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
5	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Lee Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Madeline Merrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records

(Address)

15 Filed JUL 14 1930 HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-14-30

17 I HEREBY CERTIFY, That I attended deceased from 7-2, 1930, to 7-14, 1930, that I last saw her alive on 7-14, 1930, and that death occurred, on the date stated above, at 11 AM m.

The CAUSE OF DEATH* was as follows:

Rheumatic Cardiovascular disease

(duration) yrs. 9 mos da.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Gupta, M. D.

7/14, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL 7/16 1930

20 UNDERTAKER J. Bayne Riley

ADDRESS Cambridge

Spec.—1-30—M. & T.—250 Blks.

E 58770 HEALTH DEPARTMENT—CITY OF BALTIMORE + 129 E 58770

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dolly Jones

(a) RESIDENCE NO. Russelle W Va ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 3 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22-1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	14		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) W Va

PARENTS

10 NAME OF FATHER Denny Jones

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) W. Va

12 MAIDEN NAME OF MOTHER Hattie McClung

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) W Va

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 14 1930 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13-1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to July 13, 1930, that I last saw h.. alive on July 13, 1930, and that death occurred, on the date stated above, at 12 15 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency and failure.
Rheumatic fever; Rheumatic endocarditis;
Mitral stenosis and insufficiency. C.P.C.

(duration) ... yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Hedwig Kovacs, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parcevert. W. Va	July 14 1930

20 UNDERTAKER Mary M. Schaeffer ADDRESS 1816 E. Monument

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58771

REGISTERED NO. 49 E 58771

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2200 Maryland ST. AVE. WARD 51

2-FULL NAME Mr David Fishach

(a) RESIDENCE NO. 2200 Maryland ST. Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? --- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Wid.

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Elizabeth Horner

6 DATE OF BIRTH (month, day, and year): May 25, 1848

7 AGE: Years 82 | Months 1 | Days 17 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tile Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Fishach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mrs. Bessie F. Stewart 2200 Maryland Avenue

15 Filed 7/14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 3rd, 1929, to July 12, 1930, that I last saw him alive on July 12, 1930, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Carcinoma Prostate

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Fab

(Signed) A C Mommager, M. D.

7/14, 1930 (Address) 605 E Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 7/15 1930

ADDRESS

UNDERTAKER: Henry U. Mears & Son 805 N. Calvert

Spec.—1-30—M. & T.—250 Blks

58772

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58772

CERTIFICATE OF DEATH

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO.) ST. 76 37 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Staeheli

(a) RESIDENCE NO. 3725 E. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married.

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Lena Staeheli

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER Julius Staeheli

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland.

12 MAIDEN NAME OF MOTHER Wilhemina Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland.

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

Filed 7-14-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1929, to July 12, 1930, that I last saw him alive on July 12, 1930, and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Anaemia, Secondary.

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

7-13, 1930. (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL July 14 1930

20 UNDERTAKER John G. Connelly

ADDRESS Essex

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58773

CERTIFICATE OF DEATH.

× 31 ✓ E 58773

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 16-37 ST. ..... WARD)

2-FULL NAME Henry Uhl

(a) RESIDENCE NO. Back River, near Sparrows Point ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred always yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept. 12, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Louis Uhl

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Lothof

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Louis Uhl
(Address) Essex Md.

15 Filed L 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/13/30

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1929, to 7/13/30, that I last saw him alive on 7/13/30, and that death occurred, on the date stated above, at 5:35 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

indefinite (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) unknown.
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Alex Gerasoda M. D.

7/13, 19 (Address) City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cemetery DATE OF BURIAL July 14 1930

UNDERTAKER John G. Connelly ADDRESS Essex Md

Spec.—1-30—M. & T.—250 Bks.

238698
E 58774

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58774

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 9-46 ST., WARD)

2-FULL NAME Abram b. Sickles

(a) RESIDENCE NO. 2763 Alameda Blvd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mattie E Sickles

6 DATE OF BIRTH (month, day, and year) Nov 23 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	7	20	14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Casting Dept

(c) Name of employer Baltimore Tube Works

9 BIRTHPLACE (city or town) Freehold N. J.
(State or country)

PARENTS

10 NAME OF FATHER Charles Sickles

11 BIRTHPLACE OF FATHER (city or town) N. J.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Crowson

13 BIRTHPLACE OF MOTHER (city or town) N. J.
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

Filed JUL 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7-1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 13, 1930, that I last saw him alive on July 13, 1930, and that death occurred, on the date stated above, at 5 00 A m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

Post malignant

Cerebellar Portine

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-13-30

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation

(Signed) C. H. Jones, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cemetery

DATE OF BURIAL July 15 1930

20 UNDERTAKER Chas. G. Black

ADDRESS 742 W. North Ave

1-30—M. & T.—100 B—60L

E58775

HEALTH DEPARTMENT—CITY OF BALTIMORE

E58775

CERTIFICATE OF DEATH

123

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST., ... WARD)

2-FULL NAME Margaret Roesler

(a) RESIDENCE NO 2118 Penrose ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dietrich Roesler

6 DATE OF BIRTH (month, day, and year) Mar. 12 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Laura Smith

(Address) 2118 Penrose

15 Filed JUL 14 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Ruptured Gall Bladder & Gen'l Peritonitis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... da. None

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 7/12/30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Surgical

(Signed) Charles Barnes, M. D. Coroner

July 14 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL July 15 1930

20 UNDERTAKER George L. Eshman ADDRESS 210 Fulton Ave

TION is very important See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58776

CERTIFICATE OF DEATH

44

E 58776

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST. 7-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Gardner

(a) RESIDENCE NO. 406 N. Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Gardner

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70 —			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street cleaner

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Albert Gardner

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Jane Kaisey

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Hospital records.

(Address) JOHNS HOPKINS HOSPITAL.

15 Filed 7 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-11-30

17 I HEREBY CERTIFY. That I attended deceased from 7-8, 1930, to 7-11, 1930, that I last saw h.. alive on 7-11, 1930 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Adeno-carcinoma of stomach with metastasis to Abd. Lymphatics

(duration) 6 P yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Robert V. Chenowith, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

UNDERTAKER Commissioner Health

ADDRESS JUL 14 1930

Per Wm. S. WORDAL

Spec.—1-30—M. & T.—250 Blks.

E 58777 **HEALTH DEPARTMENT—CITY OF BALTIMORE** + 49 E 58777

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto. City Hosp.

CITY OF BALTIMORE: (NO. ..... ST. 11-1 WARD)

2-FULL NAME John Adams

(a) RESIDENCE NO. 601 N. Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
78		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (City or town) Oklahoma City
(State or country) New York, Oklahoma

PARENTS

10 NAME OF FATHER Henry Adams.

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) New York.

12 MAIDEN NAME OF MOTHER Matilda ?

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Germany

14 Informant Balto City Hosp
(Address) Baltimore

15 FEB 4 1930 C. HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-8-30

17 I HEREBY CERTIFY, That I attended deceased from 6-19, 1930, to 7-8, 1930, that I last saw h[illegible] alive on 7-8, 1930, and that death occurred, on the date stated above, at 8:40 P m.

The CAUSE OF DEATH* was as follows:

Primary carcinoma of lung - left lower lobe.

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Pleural effusion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 6-26-30

Was there an autopsy? yes

What test confirmed diagnosis? autopsy.

(Signed) Fred M. Updegraff, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS JUL 14 1930

Dec. Wm. E. Woodall

Spec—12-23-21—E.B.R.S.—400 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58778

CERTIFICATE OF DEATH.

129

E 58778

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1207 N. Montford Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Tochterman

(a) Residence No. 1207 N. Montford St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Tochterman

6-DATE OF BIRTH (month, day and year) 1/7/1851

7-AGE. 79 yrs. 6 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Conrad Strasburger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Catherine Strasburger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs. Gertrude Tochterman

(Address) 1207 N. Montford Ave

15- Filed C. HAMPSON JONES, M. D. Registrar.

L 7 4 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 7-12-30.

17- I HEREBY CERTIFY, That I attended deceased from July 10 1930 to July 12 1930

that I last saw h.. alive on July 12 1930

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Hypostasis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Andrew Hunsworth M. D.

19 (Address) 2574 Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer

DATE OF BURIAL. 7/15/30 19....

20-UNDERTAKER. Mary E. Pentz

ADDRESS 1035 Hanover

Instructions on back of Certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58779

CERTIFICATE OF DEATH.

182 E 58779

1-PLACE OF DEATH

City of BALTIMORE: (No.) Gwynns Falls Park [illegible] Pool

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Brown Stitt

(a) RESIDENCE NO. 873 N. Fayette St. Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): February 3rd 1919

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	11	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Alexandria

(State or country): Va

PARENTS

10 NAME OF FATHER: Luther H. Stitt

11 BIRTHPLACE OF FATHER (city or town): Salem

(State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Blanche Witt

13 BIRTHPLACE OF MOTHER (city or town): Cross Roads

(State or country): Va

14 Informant: Lucy H. Stitt

(Address) 873 N. Fayette St

15 Filed _____ 19___ C. HAMPSON JONES, M. D. Registrar

By _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) ___

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) Chas. H. Brooks, M. D. (Coroner)

7/19 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death? ___

Former or usual residence ___

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial 7/15 1930

UNDERTAKER: H. O. Pflaguet ADDRESS 1850 N. Baker St

L 14 1930

Be sure that name, date and place of death are very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

143-001

E 58780

E 58780

CERTIFICATE OF DEATH

1—PLACE OF DEATH Woman's Hospital, Balto City

CITY OF BALTIMORE: (No. 620 N. Carey ST. 16-76 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cecelia Susannah Perrin

(a) RESIDENCE NO. 620 N Carey ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 (Life) yrs. 8 mos. 14 ds. How long in U. S., if foreign birth? 25 yrs. 8 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Lionel Perrin

6 DATE OF BIRTH (month, day, and year) Oct 28, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER John George Ochs

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Clark Wills

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Elizabeth Clark Wills Ochs

(Address) 620 N Carey St Baltimore

15 Filed JUL 14 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to July 12, 1930, that I last saw her alive on July 12, 1930 and that death occurred, on the date stated above, at 5:50 A m. E.S.T.

The CAUSE OF DEATH* was as follows:

Pelvic cellulitis following self induced abortion.

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia at.

(duration) yrs. mos. 7 ds.

Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eleso G. Woodyer, M. D.

July 14, 1930 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 7/15 1930

UNDERTAKER H. Brauns & Son

ADDRESS 1630 Gro

1-30—M. & T.—100 B—50L

E 58781

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58781

CERTIFICATE OF DEATH

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5805-Kavon Ave. ST. 26-42 WARD)

2-FULL NAME Patrick Garrity

(a) RESIDENCE NO 5805-Kavon Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Kane

6 DATE OF BIRTH (month, day, and year) 5/3/1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	2	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer City
(b) General nature of industry, business, or establishment in which employed (or employer) Highways-Dept.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Garrity

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Daugherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mamie Garrity
(Address) 5805-Kavon Ave.

15 Filed JUL 15 1930 C. HUMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorhage from nose & mouth - probably pulmonary - possibly tuberculosis
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] Coroner, M. D.

7/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 7/15/30

20 UNDERTAKER Mary T. [illegible]

ADDRESS 1735-Harford Av.

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 58782

Richard Klein

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 ✓ E 58782

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 468 S. Market Place St., 3-5 Ward)

2-FULL NAME ~~Richard~~ Michael Klein

(a) RESIDENCE NO. 468 S. Market Place St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27. 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	53 54	7	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ?
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Michael Klein

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Katie Schatzlein

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Wm K. Zeisler
(Address) 516 E. 20

15 Filed ....., 19.... Registrar

C. HAMPSON JONES, M. D.

JUL 5 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. T. Ruhrah, M. D.

July 3, 1930 (Address) 1639 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 7/5/1930

20 UNDERTAKER Geo. Leinbach

ADDRESS 525 N. Lynch

important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 58783 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 159-002 E 58783

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1304 N. Rose St. 8-16 WARD)

2—FULL NAME Melvin Cook.

(a) RESIDENCE NO. 1304 N. Rose St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Baby.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 12, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore. (State or country) Maryland.

PARENTS

10 NAME OF FATHER Mathews Cook.

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country) ~~Maryland~~ D.C.

12 MAIDEN NAME OF MOTHER Tilly Zika.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant Mathews Cook.
(Address) 1304 N. Rose St. Balto. Md.

15 Filed JUL 15 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15-30

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 15, 1930, that I last saw h[illegible] alive on July 14, 1930, and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Trouble

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rydaner M. D.

July 15 1930 (Address) 804 N. Chester St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Cemetery.

DATE OF BURIAL July 15, 1930

20 UNDERTAKER August Pasek. ADDRESS 2406 E. Ashland Ave.

1-30—M. & T.—100 B—50L

E 58784

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-103

E 58784

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp ST. 14-59 (WARD)

2-FULL NAME Inez Williams

(a) RESIDENCE NO 524 Gold St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 10-21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	1	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School gl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Raymond Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Marie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Raymond Williams

(Address) 524 Gold St

15 Filed JUL 15 1930 C. HAMPSON JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows: While crossing Street was struck & Run over by Auto

(a) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Multiple Fract Ribs L. Side — Ruptur Lung (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Gold & Ellen

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H Frame Coroner, M. D.

7/15, 1930 (Address) 2939 W. Eldern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL July 16 1930

UNDERTAKER John H Toadvine — ADDRESS 1027 Hanover

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58785

E 58785

CERTIFICATE OF DEATH.

117

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Balto Gen Hosp.

CITY OF BALTIMORE: (No. ~~318 S Monroe~~ ST. 20-28 WARD)

2-FULL NAME Margaret V. Bach

(a) RESIDENCE NO. 318 S. Monroe ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of: Thos. F Bach

6 DATE OF BIRTH (month, day, and year): Feb. 18-1870

7 AGE — Years: 60 — Months: 4 — Days: 24 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jos Stone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Hoar

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Thos F. Bach (Address) 318 So Monroe St.

15 Filed 1 5 1930 C. HAMPSON JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1930

17 I HEREBY CERTIFY, That I attended deceased from July 6 1930 to July 12 1930 that I last saw h alive on July 12 1930 and that death occurred, on the date stated above, at 8.15 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis & Coronar Dilatation

(duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Chronic Nephritis & Arteriosclerosis

(duration) 15 yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly M. D.

1/V 1930 (Address) 1071 N Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park.

DATE OF BURIAL: 7/15/1930

20 UNDERTAKER: Henry H Wiltze

ADDRESS: Edmondson

TION is very important. See instructions on back of certificate).

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58786 ✓ E 58786

E 58786

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1372 Whatcoat ST. (WARD) 15-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Young

(a) RESIDENCE NO. 1372 Whatcoat ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 11 mos. 9 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Young

6 DATE OF BIRTH (month, day, and year) Aug 3, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Invalid for yrs Baltimore

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Leonard Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ellen Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Florence Singleton

(Address) 1200 Chanderlier St

15 Filed 1930 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1930

17 I HEREBY CERTIFY That I attended deceased from Jan 7, 1930, to July 12, 1930

that I last saw h/m alive on July 12, 1930

and that death occurred, on the date stated above, at 3.55 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

Arteriosclerosis (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Age, Arteriosclerosis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. A. Wright, M. D.

(Address) 1209 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National — DATE OF BURIAL July 15 1930

20 UNDERTAKER Thomas E Kelson — ADDRESS 503 Presstman St

Spec.—1-30—M. & T.—250 Bks.

E 58787 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58787

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Redwood St. 4-30 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Cornish

(a) RESIDENCE NO. 607 Redwood St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Bell Cornish

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
65?	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. O&D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Bell Cornish (Address) 607 Redwood St

15 JUL 30 Filed ..... 19 ..... Registrar

HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1930 to July 14, 1930, that I last saw him alive on July 14, 1930, and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Cancer Carcinoma

(duration) yrs. 9 mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ?? Date of

Was there an autopsy? ??

What test confirmed diagnosis?

(Signed) H. Calder, M. D.

, 19 (Address) 607 Redwood St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem

DATE OF BURIAL 7-15 1930

20 UNDERTAKER Bennett Carlson

ADDRESS 916 Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58788

CERTIFICATE OF DEATH

38 E 58788

REGISTERED NO. 16 22

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 Mosher ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Katherine Clauson

(a) RESIDENCE NO. 1513 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leroy Clauson

6 DATE OF BIRTH (month, day, and year): Mar 24-1902

7 AGE — Years: 28 | Months: 3 | Days: 19 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Mathews Co. Va

PARENTS

10 NAME OF FATHER: Leroy Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mathews Co. Va

12 MAIDEN NAME OF MOTHER: Patrice Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mathews Co. Va

14 Informant: Leroy Clauson

(Address): 1513 Mosher St.

15 Filed: C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 13-1930

17 I HEREBY CERTIFY That I attended deceased from July 11, 1930. to July 13, 1930.

that I last saw h.. alive on July 13, 1930 and that death occurred, on the date stated above, at 11 A. m. S.T.

The CAUSE OF DEATH* was as follows:

Cerebral Meningitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 7/8/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas. E. Pell, M. D.

(Address) 713 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Williams Wharf Va.

DATE OF BURIAL: 7-15 1930

20 UNDERTAKER: David Carter

ADDRESS: 716 Gay St.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58789 57 E 58789

E 58789 REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1407 Olive ST. 23-31 WARD)

2—FULL NAME Enilde M. Ruffini

(a) RESIDENCE NO. 1407 Olive ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 26 yrs. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Brutus Ruffini

6 DATE OF BIRTH (month, day, and year): Dec 7-1868

7 AGE: Years 61 | Months 7 | Days 7 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: John Catozzi

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Lonia Barotta

12 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

13 Informant: Marie Haas

(Address): 1407 Olive st

15 Filed ..... 19..... Registrar

JAMPSON JONES, M. D.

JUL 17 1930.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1930

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1930, to July 14, 1930

that I last saw her alive on July 13 1930 at 430 m. EST.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Idem Known

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Pyelitis Idem Known (duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + laboratory Exam

(Signed) J Edward Norris, M. D.

7-15 1930 (Address) 137 East west

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy cross Cemetery

DATE OF BURIAL: July 17, 1930

20 UNDERTAKER: F. A. Swanseran

ADDRESS: 703 Hamilton

Spec.—1-30—M. & T.—250 Blks.

E 58790 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 58790

CERTIFICATE OF DEATH.

REGISTERED NO. 1560

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Blacker.

(a) RESIDENCE NO. 2047 Linton Ave ST., WARD Balto Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Louis Blacker

6 DATE OF BIRTH (month, day, and year) Nov 11, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
95	24	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Barris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER ~~Fannie Barris~~.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) 2047 Linton Ave Louis Blacker

15 Dec 15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930 to July 14, 1930, that I last saw her alive on July 14, 1930, and that death occurred, on the date stated above, at 10:05 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the lower lip — Staphylococcus infection

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phys findings

(Signed) Preston Peters M. D.

7/16 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cemetery DATE OF BURIAL July 15, 1930

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eutaw St

Spec.—1-30—M. & T.—250 Bks.

LEVIN

E 58791

E 58791 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

126

REGISTERED NO. 15821

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. ST. 1506 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Charlotte Levin.

(a) RESIDENCE NO. 1503 N. Appleton ST., WARD Balto. Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. dys. How long in U. S., if of foreign birth? yrs. mos. dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single.

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16, 1930.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city Md

PARENTS

10 NAME OF FATHER Samuel Levin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Shirley Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel Levin (Address) 1503 N. Appleton St.

15 Filed 1 5 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15/30

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1930, to July 15, 1930, that I last saw her alive on July 15, 1930, and that death occurred, on the date stated above, at 3:06 A.M.

The CAUSE OF DEATH* was as follows:

Pneumococcic Peritonitis.

Primary

(duration) yrs. mos. dys.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. dys.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? yes Date of July 13, 1930.

Was there an autopsy? no Necessary

What test confirmed diagnosis? physical findings

(Signed) Meitar B. Kirsh, M. D.

7/15, 1930 (Address) Univ Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington D.C. DATE OF BURIAL July 15 1930

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Balto St.

Spec.—1-30—M. & T.—250 Blks

E 58792

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58792

74-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2604 Jefferson ST., 7-19 WARD)

2-FULL NAME Frederick P Frey

(a) RESIDENCE NO. 2604 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) ~~WIFE of~~ Mary C. Frey

6 DATE OF BIRTH (month, day, and year) Dec 2 - 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Frederick P. Frey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Bartel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary C. Frey

(Address) 2604 Jefferson St.

JUL 15 1930

15 Filed THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 6-30, 19..., to July 13th, 19 30,

that I last saw him alive on July 13, 19 30,

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ...yrs. ...mos 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. W. Thurnam, M. D.

7/15/30 (Address) 1913 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL July 16 1930

20 UNDERTAKER Wm. E. Miller & Son

ADDRESS 2334 Jefferson St.

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58793

CERTIFICATE OF DEATH.

44 E 58793

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 7-4 WARD)

2-FULL NAME Thomas Grattan

(a) RESIDENCE NO. 416 S. Wolf St. City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Grattan

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Brooklyn (State or country) N.Y.

PARENTS

10 NAME OF FATHER John Grattan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Lordy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hosp. Records

15 Filed ....., 19 .....

C. HAMPSON JONES, M. D. Registrar

5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1930

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 12, 1930, that I last saw him alive on July 11, 1930, and that death occurred, on the date stated above, at 11:00 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Asphyxiation

(duration) 7 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) H. G. Strickland M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL July 16, 1930

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 58794

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118 500 1

E 58794

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vitto Michael

(a) RESIDENCE NO. 1008 Stiles St. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. Vitto Michael

6 DATE OF BIRTH (month, day, and year) June 20 1894.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
37	36	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Italy

(State or country)

PARENTS

10 NAME OF FATHER Tony Marshall

11 BIRTHPLACE OF FATHER (city or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Anna Stefanucci

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant Vitto Michael

(Address) 1008 Stiles St.

J. HARRISON JONES, M. D.

Filed JUL 15 1930, 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to July 12, 1930, that I last saw him alive on July 12, 1930 and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Ventral Hernia

.....

.....

.....

(duration) 9 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Failure 10 hrs

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 1008 Stiles St.

Did an operation precede death? Yes. Date of 7/12/30

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) Robert V. Ebersold, M. D.

, 19 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 16 1930
UNDERTAKER	ADDRESS
Wendell J. Heppel	300 N. Eden St.

Spec.—1-30—M. & T.—250 Bks.

E 58795 HEALTH DEPARTMENT—CITY OF BALTIMORE 7400 E 58795

CERTIFICATE OF DEATH

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1744 ST. WARD)

2-FULL NAME John Bennett

(a) RESIDENCE NO. 1340 Argyle Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M
4 COLOR OR RACE: Blk
5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land

PARENTS
10 NAME OF FATHER Solomon Bennett
11 BIRTHPLACE OF FATHER (city or town) (State or country) Mary Land
12 MAIDEN NAME OF MOTHER Josephine Bell
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mary Land

14 Informant (Address) Balto City Hospitals

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1930

17 I HEREBY CERTIFY That I attended deceased from March 6, 1930 to July 12, 1930
that I last saw him alive on July 11, 1930
and that death occurred, on the date stated above, at 2:00 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Bronchopneumonia (Terminal)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? Yes.
What test confirmed diagnosis? Clinical Findings

(Signed) Harry F. Smith M.D.
19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL July 15 1930

20 UNDERTAKER Samuel T. Newsom ADDRESS 578 Bdle

L 151 38

Spec.—1-30—M. & T.—250 Bks.

E 58796 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58796

31

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 647 N Calhoun St., (WARD)

2-FULL NAME Ruby Wallace

(a) RESIDENCE NO. 647 N. Calhoun ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed or Divorced (write the word) Married

5a If married, widowed or divorced HUSBAND of or) WIFE of Bennie Wallace

6 DATE OF BIRTH (month, day, and year) Dec 6-1900

7 AGE Years 29 Months 7 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Jeffers Diggs

11 BIRTHPLACE OF FATHER (City or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Autumn

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Va

14 Informant Bennie Wallace (Address) 647 N. Calhoun

C. HARRISON JONES, M.

15 Filed JUL 15 1930 19 Reg. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13. 1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to July 13, 1930, that I last saw her alive on July 13, 1930, and that death occurred, on the date stated above, at 3.40 p m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Necropsy

(Signed) W. S. Hoviell M. D.

7/15, 1930 (Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Williams Whf Co

DATE OF BURIAL July 15 30

20 UNDERTAKER Bennie L. Hensley

ADDRESS 598 N Bdle

Spec.—1-30—M. & T.—250 Bks

58797

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-01 L 58797

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1827 Bolton St. (WARD) 14-20

2-FULL NAME Rebecca Murphy Galbreath.

(a) RESIDENCE NO. 1827 Bolton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander D. Galbreath

6 DATE OF BIRTH (month, day, and year) Sept. 6, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) York Co. (State or country) Pa.

PARENTS

10 NAME OF FATHER Dr. Wm. Ferris Smith

11 BIRTHPLACE OF FATHER (city or town) Pa. (State or country)

12 MAIDEN NAME OF MOTHER Hannah Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) Pa. (State or country)

14 Informant Mrs. Pearl S. Galbreath (Address) 1827 Bolton St.

C. THAMPSON JONES, M.

15 Filed 1 15 1930, 19 BY Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to , 19 ; that I last saw h alive on July 14, 1930, and that death occurred, on the date stated above, at 3.50 a.m. DST.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage Ed

paralysis (duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) arterio sclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter S. Willett, M. D.

19 30 (Address) 2220 Harrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pine Grove Cem. York Co. Pa.	July 17 1930
UNDERTAKER Wm. Hutchison Sons	ADDRESS North Pa

1-30—M. & T.—100 B—50L

E 58798

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58798

CERTIFICATE OF DEATH

113

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 Valley Street ST. 10-14 WARD)

2-FULL NAME Frank Risso

(a) RESIDENCE NO 928 Valley Street ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 3/8/1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	4	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Ben H. Risso

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary T. Sybert

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.
(State or country)

14 Informant Ben H. Risso
(Address) 928 Valley Street

JUL 15 1930 HAMPSON JONES, M. D.

File No. ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

..... (duration) ..... yrs. about mos. 7 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) ..... Coroner, M. D.

7/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hall's Cem. N. Y.

DATE OF BURIAL 7/15/19 30.

20 UNDERTAKER George J. Pulaski

ADDRESS 1735 Hanover

TION IS VERY IMPORTANT. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58799

E 58... HEALTH DEPARTMENT—CITY OF BALTIMORE

99.002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 27-53 WARD

CITY OF BALTIMORE: (NO.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Oberleitner

(a) RESIDENCE NO. 5002 Elm ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Oberleitner

6 DATE OF BIRTH (month, day, and year) July 7, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	49	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Gratz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records (Address)

15 Filed ..., 19.. Registrar

HARRISON JONES, M.D.

7-15-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to July 13, 1930, that I last saw her alive on July 13, 1930, and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Bilateral bronchiectasis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

7-14-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL July 16 1930

20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son — ADDRESS 801 N. Fayette

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58800

38 E 58800

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 208 Rock ST. 16-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Nicholson

(a) RESIDENCE NO. 208 Rock ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	colored	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	29	-	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work chauffeur of

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Philip Nicholson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Helen Spence

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Helen Nicholson Ray

(Address) 6619 Pimlico Road

15 Filed JUL 15 1930 C. HAMPSON JONES, M. D. or Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to July 12 1930, that I last saw h[illegible] alive on July 12, 1930 and that death occurred, on the date stated above, at 1.30 9 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) mild endocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. [illegible], M. D.

, 19 (Address) 95 Hodge

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. B. Zion Cemetery

DATE OF BURIAL July 15, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N Schroeder St.

Spec.—1-30—M. & T.—250 Blks

Frederick B Berthing ✓

E 58801 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58801

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 19-28 ST. (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick ~~Berthing~~ B. Berthing

(a) RESIDENCE NO. 1816 W. Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Oct. 15, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	8	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hatter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick ~~Berthing~~ Berthing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Brackland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of
(Address) Balto. City Hosp.

15 7-15-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-13-30

17 I HEREBY CERTIFY, That I attended deceased from 3-19-30, 19..., to 7-13-30, 19...

that I last saw him alive on 7-13-30, 19...

and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate with metastases to bladder

(duration) Unknown

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 7-8-30

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Fred W. Dickmann, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] Cathedral DATE OF BURIAL 7/16 1930

20 UNDERTAKER Frederick A. Cole ADDRESS 1200 N. Fulton Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 58802

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58802

CERTIFICATE OF DEATH

89

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3212 Juneau Place ST. 16-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline Eisinger

(a) RESIDENCE NO. 3212 Juneau Place ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 10 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced (or) ~~WIFE of~~ Leonard Paul Eisinger

6 DATE OF BIRTH (month, day, and year) September 10/66

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Simon Wetzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Leonard P. Eisinger

(Address) 3212 Juneau Place

15 7-15-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/13/30

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1930, to July 13, 1930, that I last saw her alive on July 13, 1930 and that death occurred, on the date stated above, at 4 P. M. D.S.T.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis cum
Angina Pectoris

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Hyde M. D.

7/14, 1930 (Address) 1100 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL July 16th 1930

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument St

Spec.—1-30—M. & T.—250 Bks

Jo Valentine
24 S Broadway

E 58803 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 58803

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE, (No. 3424 East Balto ST. No-11 WARD)

2-FULL NAME Mary A. Slaughter

(a) RESIDENCE NO. 3424 East Balto ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha

6 DATE OF BIRTH (month, day, and year) Nov 9th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	8	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Minister of
(b) General nature of industry, business, or establishment in which employed (or employer) Gospel
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER Spencer Adolphus
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Martha S Slaughter
(Address) 3424 E. Balto

15 Filed JUL 15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July - 14 - 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to July 13, 1930, that I last saw h— alive on July 13, 1930, and that death occurred, on the date stated above, at 4:45 m.

The CAUSE OF DEATH* was as follows:

I
Carcinoma of Abdomen
(duration) 1/4 yrs. mos ds.
CONTRIBUTORY (Secondary) Diabetes
(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Joseph L. Valentine D, M. D.
July 14, 1930 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn — DATE OF BURIAL 7/16 1930

20 UNDERTAKER W. S. Cook — ADDRESS 1217 St Paul

1-30—M. & T.—100 B—50L

E 58804

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58804

REGISTERED NO. + 199

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mun Hosp (St.) 4-30 (Ward)

2-FULL NAME Ernest Nugent

(a) RESIDENCE NO. 2015 Flagler ST. N.W. WARD Wash. D.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35?				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant E. Emerson

(Address) 1432 Irving St. N.W.

15 Filed 1/5 1930 C. HARRISON JONES, M. D. Registrar

By Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto truck in which he was riding ran into stationary automobile

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Savage Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. D. Frances, M. D. Coroner

1/13, 1930 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wash. D.C.

DATE OF BURIAL 1/15 1930

20 UNDERTAKER E. Emerson

ADDRESS 1432 Irving

Spec.—1-30—M. & T.—250 Bks

E 58805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 15 1001 E 58805

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Union Memorial Hosp ST. 12-49 WARD)

2-FULL NAME Francis Wenk

(a) RESIDENCE NO. Welcome, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 78 ds. How long in U. S., if of foreign birth? ✓ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) March 21-1930

7 AGE	O Years	3 Months	22 Days	If LESS than 1 day, ...hrs. or ....min.
			24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Welcome, Md

(State or country)

PARENTS

10 NAME OF FATHER James Wenk

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Mildred Stotte

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant James Wenk

(Address) Welcome Md

Filed 7-15-1930 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15th 30

17

I HEREBY CERTIFY, That I attended deceased from April 15th, 1930, to July 15th, 1930,

that I last saw him alive on July 14th, 1930,

and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Congenital hydrocephalus

(duration) Life mos ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? Yes Date of July 14th 30

Was there an autopsy? Yes

What test confirmed diagnosis? Exploration of skull

(Signed) Jesse L. Feiser, M. D.

7-15-1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Welcome Md

DATE OF BURIAL 7/15/30

UNDERTAKER Harry A Wibbe

ADDRESS 1101 Edmondson Ave

Spec.—1-30—M. & T.—250 Bks.

58806

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 E 58806

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 12 Club Road (St.) Roland Park (WARD) 22-53

2-FULL NAME Clarence Irving Reynolds

(a) RESIDENCE No. 12 Club Road Roland Park WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anita Easter Reynolds

6 DATE OF BIRTH (month, day, and year) Sept 7 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant Secretary

(b) General nature of industry, business, or establishment in which employed (or employer) 4th Mercantile Trust

(c) Name of employer Company

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Henry D. Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Fannie Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Anita Easter Reynolds (Address) 12 Club Road Roland Park

Filed 7-15-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 14, 1930, that I last saw h[illegible] alive on July 14, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: *

Coronary Occlusion

" Angina Pectoris "

(duration) Last few hours. mos. ds.

CONTRIBUTORY (Secondary) Essential Hypertension.

(duration) 4 yrs. + mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) M. Gibson Forter, M. D.

7/15, 1930 (Address) 482 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL July 16 1930

UNDERTAKER Henry Jenkins & Son

ADDRESS Eutaw & Mulberry Sts

1-30—M. & T.—100 B—50L

Anna Manides

E 58807

HEALTH DEPARTMENT—CITY OF BALTIMORE

143-00 E 58807

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST., 1-3 (WARD)

2-FULL NAME Anna Manides

(a) RESIDENCE NO 6 S. Collington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Kasmas Manides

6 DATE OF BIRTH (month, day, and year) Jan 9/1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	6	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of Industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) Sparrow's Pt.
(State or country) Md.

PARENTS

10 NAME OF FATHER Peter Pernis

11 BIRTHPLACE OF FATHER (city or town) Bohemia
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Bohemia
(State or country)

14 Informant Kasmas Manides
(Address) 6 S. Collington Ave

15 Filed 7/15, 192 C. HAMPSON JONES, M. D.
1 6 1930 Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
General Toxemia due to criminal abortion about March 5th

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? about Mar

Did an operation precede death? yes Date of 23rd

Was there an autopsy? No (Pelvic Drainage)

What test confirmed diagnosis?

(Signed) J. H. Hatem, M. D.
Coroner

(Address) 508 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL June 17 1930

20 UNDERTAKER F. W. Ozazewski ADDRESS 1830 Eastern Ave

TION IS very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

E 58808 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58808

CERTIFICATE OF DEATH.

REGISTERED NO. 90
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 3034 Barclay St. 17-50 WARD)

2-FULL NAME Coleman L. Gilbert

(a) RESIDENCE NO. 3034 Barclay ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 4 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Gilbert

6 DATE OF BIRTH (month, day, and year) 10-19-1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	8	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer U S M

9 BIRTHPLACE (city or town) (State or country)

PARENTS
10 NAME OF FATHER John
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Ellen Md
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mr. John Cook
(Address) 105 Park Lane

15 Filed 1 6 1930, 19 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 5th, 1930. to July 15 1930.
that I last saw him alive on July 12th 1930.
and that death occurred, on the date stated above, at 2:05 P. m.

The CAUSE OF DEATH* was as follows: Probably "old age" would come nearest. General debility was positive. July 5th, 30. A considerable diarrhoea appeared. Patient was recovered from by July 13, 30. Direct cause
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. was due to condition.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of X
Was there an autopsy? No.
What test confirmed diagnosis? Nothing special.
(Signed) C. H. Jones M. D.
7/15, 1930 (Address) 2700 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wesleyan Cem Aberdeen Md — DATE OF BURIAL 7/16/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

L 1 6 1930

Spec.—1-30—M. & T.—250 Blks

Dr Fischer
N. Washington

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58809

CERTIFICATE OF DEATH.

45 E 58809

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1737 N. Chester St. 8-17 WARD)

2-FULL NAME Emma Bailone

(a) RESIDENCE NO. 1737 N. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced (or) WIFE of Pascal Bailone

6 DATE OF BIRTH (month, day, and year) June 2 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christine Spell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Pascal Bailone (Address) 1737 N. Chester St.

15 Rec'd 7 16 1930, 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15-30

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to July 15, 1930, that I last saw h[illegible] alive on July 15, 1930, and that death occurred, on the date stated above, at 9 30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Centemum & Intestinis

(duration) yrs. 1 mos 28 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5 weeks ago

Was there an autopsy? No

What test confirmed diagnosis? Exploratory operation

(Signed) Kurt Fisher, M. D.

7/15 1930 (Address) 1823 N. Wash. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 7/18 1930

UNDERTAKER William Cook

ADDRESS 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58810

E 58810

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 Aisquith Street ST., 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sr. M. Gorgonia Knecht

(a) RESIDENCE NO. Convent of Notre Dame ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 065

(b) General nature of industry, business, or establishment in which employed (or employer) Sisters of Notre Dame

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER John Knecht

11 BIRTHPLACE OF FATHER (city or town) Bavaria
(State or country)

12 MAIDEN NAME OF MOTHER Magdalen Huber

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Sistrs of Notre Dame
(Address)

15 JUL 16 1930, 19 C. HAMPSON JONES, M. D.
Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 15, 1930,

that I last saw h alive on July 15, 1930

and that death occurred, on the date stated above, at 3.50 A. M. m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Chronic
Atheno Sclerosis
Coronary Embolus

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual Symptoms

(Signed) J. J. Kelly, M. D.

7/15, 1930 (Address) 106 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greentown Private

DATE OF BURIAL July 17 1930

20 UNDERTAKER Frank A. Fink

ADDRESS 915 N. Gay

Spec.—1-30—M. & T.—250 Bks.

E 58811

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 58811

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Infirmary ST., 813 WARD)

2-FULL NAME Mrs. Mary Chalkley

(a) RESIDENCE NO. 1225 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Albert Chalkley.

6 DATE OF BIRTH (month, day, and year) 8-8-1872

7 AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
	58	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Harry Cartlidge

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Stenner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Albert R. Chalkley
(Address) 1225 N. Washington St.

15 Filed JUL 16 1930, 19 Registrar JOHN JONES, M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to July 14, 1930, that I last saw h.e alive on July 14, 1930, and that death occurred, on the date stated above, at 1:35 P.m.

The CAUSE OF DEATH* was as follows:

Rheumatic endocarditis with Thrombosis of right femoral vein and Pulmonary Infarcts

Approximate (duration) 30 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Vernon K. Norwood, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Johns Cemetery (Waverly)	7-18-1930
UNDERTAKER Wendell E. Humphreys	ADDRESS 2416 8 Eutaw Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58812

E 58812

CERTIFICATE OF DEATH.

164

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 Enson ST. 10-14 WARD)

2-FULL NAME Samuel J Chase

(a) RESIDENCE NO. 825 Enson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Adline Roberts
(Address) 825 Enson St

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar
By .....

JUL 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1930

17 I HEREBY CERTIFY, That I attended deceased from at intervals from arterio sclerosis, 19..., to July 13, 1930.

that I last saw him alive on July 12, 1930,

and that death occurred, on the date stated above, at 9.25 P. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

(duration) about yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Infirmities

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Chemical

(Signed) C & P Carman, M. D.

July 14 1930 (Address) 1701 N. Carolina st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Wellsburg Md. DATE OF BURIAL 7-16 1930

UNDERTAKER Dent & Carlson ADDRESS 5th & Penna Ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—350 Blks.

E 58813

LE 58345 LE 58313

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. 11-24 ST. (WARD)

2-FULL NAME George McCarte

(a) RESIDENCE NO. 44 E Orchard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	black	married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work porter 370

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Records (Address) Johns Hopkins Hospital

15 Filed JUL 16 1930 C. HAMPSON JONES, M. D. Registrar.

By Lyle

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14-1930

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1930, to July 14, 1930, that I last saw him alive on July 14, 1930, and that death occurred, on the date stated above, at 1.20 p m.

The CAUSE OF DEATH* was as follows:

Anemia 2nd, obstruction the left bronchus

(duration) yrs. 10 mos da.

CONTRIBUTORY (Secondary) Syphilitic history

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Hedwig Kaerny, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 7-16 1930

20 UNDERTAKER Daniel Eaton

ADDRESS 916 Cathedral

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58814

E 58814

CERTIFICATE OF DEATH.

REGISTERED NO. 7069

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2245 W Fayette ST. WARD)

2-FULL NAME Robt A McAllister

(a) RESIDENCE NO. 2245 W Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. mos. ds. How long in U. S., if of foreign birth? 88 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W Lite	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jennie Culligan McAllister

6 DATE OF BIRTH (month, day, and year) Jan 17. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	6.	27 14.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired - Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Robt. A. McAllister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md.

14 Informant Virginia McAllister

(Address) 2245 W. Fayette St. Balto. Md.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/14/30 19

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to July 13, 1930, that I last saw him alive on July 13, 1930, and that death occurred, on the date stated above, at 4.15 Am.

The CAUSE OF DEATH* was as follows:

Old age

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Fracture neck of Femur

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas A Schaefer, M. D.

, 19 (Address) 2905 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL 7/16/1930

20 UNDERTAKER Geo. Lindsay & Son. ADDRESS N. Lyndhurst

Spec.—1-30—M. & T.—250 Blks

E 58815 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58815

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2111 Ramsay St. 20-69 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Spielman

(a) RESIDENCE No. 2111 Ramsay ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 24, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob Spielman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mt Knobe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Kurschl
(Address) 2111 Ramsay St

15 Filed ..., 19... C. HAMPSON COOKS, M. D. Registrar

JUL 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13-1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 13, 1930, that I last saw him alive on July 13, 1930, and that death occurred, on the date stated above, at 3.32 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis - Endocarditis
Cerebral Hemorrhage
Chronic Interstitial Nephritis
Senile Dementia ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Martin L. Hyatt M. D.

(Address) 2157 Eutaw Av July 15 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL July 16 1930

20 UNDERTAKER George L. Schmidt — ADDRESS 2101 Frederick Ave.

Spec. 6-9-13—H. P. Co.—1000 Blks.

E 58816 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58816

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 S. Streeper ST. 12 WARD)

2-FULL NAME Martin Balster (Balcer)

(a) RESIDENCE. NO. 617 S. Streeper ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Michael Balcer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Paulene Waber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Mrs Balcer 407 S. Brew St.

15 Filed 7-16-1930 R. SIMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1930

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 16, 1930,

that I last saw him alive on July 15, 1930,

and that death occucced, on the date stated above, at 2300 m.

The CAUSE OF DEATH* was as follows:

Embolism, causing hemiplegia of the right side, due to chronic valvular heart disease, and chronic nephritis (duration 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema (duration) yrs. mos. 1 d.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) I. B. Bronushas, M. D.

7-16-30, 19 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See cevecse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. DATE OF BURIAL: July 19 1930

20 UNDERTAKER: Stephen A. Fralkowski ADDRESS: 1000 S. Ken...

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58817 31 E 58817

E 58817

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1204 Chatham ST. 8-12 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rufus Bacon

(a) RESIDENCE NO. 1204 Chatham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE: Years 48; Months; Days; If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Washer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Potomac Md. Dairy.

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Bacon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Morton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

10a Informant Mrs. Malone

(Address) 1204 Chatham St.

Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14/30

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1931, to July 14, 1930,

that I last saw h.. alive on July 14, 1930, 12-30 Noon m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Acute Nephritis Arteriosclerosis

(duration) yrs. 1 mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Wm. McCrodden, M. D.

7/16 1930 (Address) 703 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Drakesbranch Va

DATE OF BURIAL July 18, 1930

ADDRESS

UNDERTAKER Emmett H. Hensley

Middle

L 16

Spec.—1-30—M. & T.—250 Bks

E 58818

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58818

CERTIFICATE OF DEATH.

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 708 Edmondson ST. 16-N (WARD)

2-FULL NAME James Barton

(a) RESIDENCE NO. 708 Edmondson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14-1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None do
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Lucy Saunders

13 BIRTHPLACE OF MOTHER (city or town) N C
(State or country)

14 Informant Mary Barton
(Address) 708 Edmondson Ave

15 Filed 1 6 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15/30

17 I HEREBY CERTIFY, That I attended deceased from July 13, 19 30 to July 15, 19 30,
that I last saw him alive on July 15, 19 30,
and that death occurred, on the date stated above, at 9 30 A m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Primary)
(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H. C. Carter, M. D.
, 19 (Address) 1522 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL July 15, 30

20 UNDERTAKER Samuel L. Hemsley ADDRESS 1538 McCulloh

Spec.—1-30—M. & T.—250 Bks.

E 58819 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58819

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2608 Puget ST. 25-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs J. Ware

(a) RESIDENCE NO. 2608 Puget ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 13 1881

7 AGE: Years 49 Months 1 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Pitts Co. Ind

PARENTS

10 NAME OF FATHER: Richard M. Ware

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary A Gamble

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mary Ware

(Address) 2608 Pennsylvania Ave, Balto, Md.

Filed JUL 16 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 30

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1930, to July 14 30

that I last saw him alive on July 14, 1930,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert Dawson M. D.

19 (Address) 1900 Eastern Ave Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: D.M.C. Auburn Cem

DATE OF BURIAL: July 17 30

20 UNDERTAKER: Edmund I. Sundelof

ADDRESS 1900 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58820

CERTIFICATE OF DEATH

129 E 58820

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 N. Fulton Ave. ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C, Skinner.

(a) RESIDENCE NO. 920 N. Fulton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25.1852.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington Ohio.

PARENTS

10 NAME OF FATHER Alfred Skinner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio.

12 MAIDEN NAME OF MOTHER Mary Virture.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio.

14 Informant Miss Laura Skinner

(Address) 920 N. Fulton Ave.

Filed JUL 16 1930, 19 J. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-15-30

17 I HEREBY CERTIFY, That I attended deceased from 7-1-30, 19..., to 7-15, 1930, that I last saw h alive on 7-14-, 1930 and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Uremia Chronic Nephritis

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bay D W Cressy, M. D.

7/11/30 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Old Washington Ohio.

DATE OF BURIAL: July 16, 1930

20 UNDERTAKER: Chas. P. Fraser & Son

ADDRESS: 1118 W. Royal Ave

Spec.—1-30—M. & T.—250 Bks.

E 58821 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58821

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 117 N Ann St (ST.) 6-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry O Whittemore

(a) RESIDENCE NO. 117 N Ann St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E Whittemore

6 DATE OF BIRTH (month, day, and year) Feb 3 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	5	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS
10 NAME OF FATHER Ed Whittemore
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co.
12 MAIDEN NAME OF MOTHER Henrietta Cook
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co.

14 Informant Sarah E Whittemore
(Address) 117 N Ann St

15 Filed 1-6 1930 Registrar C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 30

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to July 14, 1930, that I last saw h[illegible] alive on July 14, 1930, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

1 Hypostatic Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bacteremia Balto

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Alan B Layman, M. D.
Nov 1, 1930 (Address) 718 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 19 1930

20 UNDERTAKER John Ellert — ADDRESS 208 Calvert

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58822

E 58822

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals 18-26

CITY OF BALTIMORE: (NO. ST. & WARD)

2-FULL NAME Etta Graves

(a) RESIDENCE NO. 520 N. Schroeder ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles

6 DATE OF BIRTH (month, day, and year) May 4, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
36	35	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Roberts on

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Kate Alor

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Records of (Address) Balto. City Hosp.

15 Filed JUL 16 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-13-30

17 I HEREBY CERTIFY, That I attended deceased from 7-12-30, 19, to 7-13-30, 19,

that I last saw h alive on 7-13-30, 19,

and that death occurred, on the date stated above, at 4:15 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic & acute.

(duration) UNKNOWN- yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical exam.

(Signed) Paul Podget, M. D.

7-15-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cem. DATE OF BURIAL July 16 1930

UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Division

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58823

CERTIFICATE OF DEATH.

7 E 58823

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1026 E. 20th ST., 9-16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanley L. Campbell Jr.

(a) RESIDENCE NO. 1026 E. 20th ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 4/22

7 AGE: Years 8 | Months 2 | Days 11 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Stanley L. Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Agnes Kissner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Agnes Campbell (Address) 1026 E. 20th

15 Filed JUL 16 1930 C. HAMPSON JONES, M.D. Registrar No.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 15/30

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 25, to July 15, 19 30,

that I last saw h.im alive on July 13, 19 30,

and that death occurred, on the date stated above, at 3 30 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Mental defficiency - Cardio-spasm

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Starvation (Refused to Eat)

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frederick V. Reuter, M. D.

7-15, 19 30 (Address) Pikesville Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk

DATE OF BURIAL: 7/17 1930

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58824

90 ✓ E 58824

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 706 Mura ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Bond Williford

(a) RESIDENCE NO. 706 Mura ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apl 2/13

7 AGE — Years: 17 | Months: 3 | Days: 13 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jas. B. Williford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Durham N. C.

12 MAIDEN NAME OF MOTHER: Minnie M. Blackstock

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mrs A. Blackstock

(Address): 706 Mura St

15 Filed 1 6 1930, 19 HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 15/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1928, to July 15, 1930, that I last saw h-im alive on July 15, 1930 and that death occurred, on the date stated above, at 1020 A. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Organic Heart.

(duration) 15 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Robert Keech, M. D.

July 15, 1930 (Address) 2502 Calvert Ln Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: 7/17 1930

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58825 90 ✓ E 58825

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 58825

1-PLACE OF DEATH

City of Baltimore: (No. 827 Hanover St. St. 22-31 Ward)

2-FULL NAME Pompy Hawkins.(C)

(a) RESIDENCE NO. 827 Hanover St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ---mos.---ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced, HUSBAND of Annie Hawkins.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	59	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Charles Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Annie Hawkins.(C) wife.
(Address) 827 Hanover St.

Filed JUL 16 1930 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? No.
Did an operation precede death? Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry
(Signed) Otto M. Reinhardt, M. D.
7/16, 1930 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn ct

DATE OF BURIAL July 18 1930

20 UNDERTAKER C. L. Brown & Son

ADDRESS 108 W. Monu

Fill in all items in plain words. Items 1 to 20 are important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 58826

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58826

161-001

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2314 McCulloh ST., WARD) 13-54

2—FULL NAME Daisy Brauns

(a) RESIDENCE NO. 2314 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/15/30

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or 5 mins

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edgar Brauns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Nannie Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Nannie Brauns

(Address) 2314 McCulloh St

15 FILED 1 6 1930, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/15/30

17 I HEREBY CERTIFY, That I attended deceased from 7/15, 19 30, to 7/15, 19 30

that I last saw h[illegible] alive on 7/15, 19 30

and that death occurred, on the date stated above, at 7.35 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Miscarriage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ed Dell, M. D.

, 19 (Address) 713 N. Grmdy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUL 1 1930

Spec.—1-30—M. & T.—250 Blks.

Chiveral

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58827 E 58827 118-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST. 2-4 WARD)

2-FULL NAME William Chiveral

(a) RESIDENCE NO. 2020 Eastern Ave ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12/9/86

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	-7	-7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none / Cook

(b) General nature of industry, business, or establishment in which employed (or employer) — ONE

(c) Name of employer Buettners Restaurant

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mattie Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 16 1930 C. HARRISON JONES, M. D. Registrar

By —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-16-30

17 I HEREBY CERTIFY, That I attended deceased from 7-2-, 19 30, to 7-16-, 19 30, that I last saw h alive on 7-16, 19 30, and that death occurred, on the date stated above, at 9 22 a m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 7/13/30

Was there an autopsy? no SW

What test confirmed diagnosis? X-ray

(Signed) S. Evans, M. D.

July 16th (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL July 18 1930

20 UNDERTAKER Henry Sander & Sons Inc.

ADDRESS Baltimore St. & Broadway.

Spec.—1-30—M. & T.—250 Bks.

E 58828 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 58828

CERTIFICATE OF DEATH.

REGISTERED NO. 45-58 29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3725 Parkheights Ave ST. ..... WARD)

2-FULL NAME Fannie Nathanson

(a) RESIDENCE NO. 3725 Parkheights ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 46 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Adolph L. Nathanson

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Adolph L. Nathanson 3725 Parkheights ave

15 Filed JUL 17 1930 C. HAMPSON JONES, M. D. Registrar By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16/30

17 I HEREBY CERTIFY, That I attended deceased from May 8 1930, to July 16, 1930, that I last saw h..... alive on ....., 19..... and that death occurred, on the date stated above, at 945 P.M. ✓ J

The CAUSE OF DEATH* was as follows:

Chronic diffused Nephritis
Hypertension, Cardiac
hypertrophy, dilatation

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) acute Parolitis

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical. Lab.

(Signed) D.G. Nicholson, M. D.

7/16 1930 (Address) 2230 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mosh Road — DATE OF BURIAL July 17, 1930

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto

Spec.—8-16-29—L. F. S.—100 Bks.

E 58829

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58829

CERTIFICATE OF DEATH

65-09

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 N. Collington ave ~~ST.~~ 7th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alois Zeleny.

(a) RESIDENCE NO. 725 N. Collington Ave ST., 7th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Frances Zeleny

6 DATE OF BIRTH (month, day, and year) January 11 1856

7 AGE Years	Months	Days	10 IF LESS than 1 day, hrs. or min.
74	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (~~City~~ or town) Vostrov

(State ~~or country~~) Czecho-Slovakia

PARENTS

10 NAME OF FATHER Kvirin Zeleny

11 BIRTHPLACE OF FATHER (~~City~~ or town) Vostrov

(State or country) Czecho-Slovakia

12 MAIDEN NAME OF MOTHER Katherina

13 BIRTHPLACE OF MOTHER (city or town) Vostrov

(State or country) Czecho-Slovakia

14 Informant Frances Zeleny

(Address) 725 N Collington Ave

15 Filed ..... C. HAMPSON JONES, M. ~~Registrar~~

..... 19 ..... by .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from May, 1929, to July 16, 1930, that I last saw h alive on July 16, 1930 and that death occurred, on the date stated above, at 3:00 P m.

The CAUSE OF DEATH* was as follows:

Chronic Lymphatic Leukemia

Ostalgia (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Embolism (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Blood Picture

(Signed) Geza Lakovay, M. D.

19 (Address) 2200 E Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Odd Fell Cem

DATE OF BURIAL 7/20 1930

20 UNDERTAKER August Passek

ADDRESS 2406 Ashland Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58830

99-002

E 58830

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital Ward) 25-15

2-FULL NAME John E. Simms.

(a) RESIDENCE NO. 3709 Fifth St. Brooklyn. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced, HUSBAND of Way Simms.

6 DATE OF BIRTH (month, day, and year) February 17, 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	59	4	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer.
(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R.R.Co.
(c) Name of employer Baltimore, Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Alexander Simms.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margaret A. Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Joseph T. Simms. (brother)
(Address) 607 Ingleside Ave Catonsville

15 Filed 7/17 1930 C. HAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis.

Pulmonary Hemorrhage.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 3700 5th st. Brooklyn

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Leonhardt, M. D.

7/16 1930 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bel Air Md St John's Cem	July 18 1930
20 UNDERTAKER A. Howard Evans	ADDRESS 3016 Frat Ave

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58831

CERTIFICATE OF DEATH

REGISTERED NO. 58831

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. B & O Train en route St. Ward) 24-34

2-FULL NAME George Morris Ernst

(a) RESIDENCE NO. 126 E. Delaware Ave St. Newark, Del. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~5~~ yrs. ~~mos.~~ 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace May Ernst

6 DATE OF BIRTH (month, day, and year) July 11, 1889.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	41		3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Signal-man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B & O. R. R. Co

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER John F. Ernst

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Frazier

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant A. Lee Wilson Brother in Law
(Address) 1601 Bolton St. M. D.

15 Filed ..... C. HAMPSON JONES, Registrar
By .....

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured Skull, Accidental Death Struck by railway train.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Newark, Del.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Augustus T. Feltz, M. D.

7/14, 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Christian Church

DATE OF BURIAL July 17 1930

20 UNDERTAKER A. Howard Evans 38

ADDRESS E. Fayette

1-30—M. & T.—100 B—50L

E 58832

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58832

CERTIFICATE OF DEATH

REGISTERED NO. 188-103

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home July 9-46 ST., WARD)

2-FULL NAME Edith Darsch

(a) RESIDENCE NO 1623 E 25th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H Darsch

6 DATE OF BIRTH (month, day, and year) Oct-14-1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	9	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Granville Bruce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Md

14 Informant W. H. Darsch

(Address) 1623 E 25th St

15 Filed ... 1930 C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto in which she was riding collided with truck at intersection

a (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Ruptured Cerebellum (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Madison & Bdwy

Did an operation precede death? no Date of

Was there an autopsy? Yes Chem & Phy findings

What test confirmed diagnosis?

(Signed) L. Hamm, M. D. Coroner

16, 1930 (Address) 29 34 Mt Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leda Hillsboro DATE OF BURIAL July 18, 1930

20 UNDERTAKER E. Howard Evans 38 ADDRESS E Fort Ave

TION IS very important. See instructions on back of certificate

Spec.—1-30—M. & T.—250 Bks

E 58833

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58833

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 N. Rose ST. 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Tinup

(a) RESIDENCE NO. 806 N. Eutaw ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Tinup

6 DATE OF BIRTH (month, day, and year) Nov. 5, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Tierney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Rose Albert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant John M. Tinup

(Address) 806 N. Eutaw St.

15 Filed 19 C. HAMPSON JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17—30

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 17, 1930, that I last saw her alive on 7/14, 1930, and that death occurred, on the date stated above, at 5:00 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Asthenia not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Carl B Roelling, M. D.

, 19 (Address) 1822 N Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL July 21 1930

20 UNDERTAKER Wm. C. Miller & Son

ADDRESS 2334 Jefferson St.

William F. Green

1-30—M. & T.—100 B—50L

E 58834½

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

17 E 58834

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital St. 19-27 WARD)

2-FULL NAME Willian F. Green

(a) RESIDENCE NO 322 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 14/1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. F. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Winifred L. Corbin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Winifred L Green

(Address) 322 N. Stricker St

Filed ..... 192 By ..... Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis
(Probably Ruptured Appendix)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 15/30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Carter Coroner, M. D.

19 7/16/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL 7/17/30

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 32 [illegible]

17 1930

Spec.—1-30—M. & T.—250 Blks

E 58835 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58835

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 3-4 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick H. Dougherty

(a) RESIDENCE NO. 503 S. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Records of

(Address): Baltimore City Hosp.

15 Filed 7-7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-14-30

17 I HEREBY CERTIFY, That I attended deceased from 4-5-22, 19..., to 7-14-30, 19...,

that I last saw him alive on 7-14-30, 19...,

and that death occurred, on the date stated above, at 10:30 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padget, M. D.

7-16, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Hearts Cem.

DATE OF BURIAL: July 17 1930

UNDERTAKER: Kelly & Leibe Inc.

ADDRESS: 503 S. Wolfe

Spec.—1-30—M. & T.—250 Bks

E 58836 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58836

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 7-13 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Fultz

(a) RESIDENCE NO. 1645 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willie Fultz.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER George Edwards

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Records of (Address) Baltimore City Hospitals

15 Filed JUL 17 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-14-30

17 I HEREBY CERTIFY, That I attended deceased from 7-8-30, 19..., to 7-14-30, 19...,

that I last saw her alive on 7-14-30, 19...,

and that death occurred, on the date stated above, at 10:20 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) Gangrene of feet

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Exam. lab.

(Signed) Paul Padget., M. D.

7-5, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Petersburg Va

DATE OF BURIAL July 15, 1930

20 UNDERTAKER Mrs. Ida Knowles

ADDRESS 1705 E. Madison

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58837

CERTIFICATE OF DEATH.

101 E 58837

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2205 Harford Rd (St.) 8-45 (WARD)

2-FULL NAME Gilbert Schuenholz

(a) RESIDENCE NO. 2205 Harford Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Dec 4, 1929

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
		7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER William J Schuenholz

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Fannie E Schuenholz

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Wm. Schuenholz
(Address) 2205 Harford Rd.

15 Filed ..... 19 ..... C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, year) July 16/30

17 I HEREBY CERTIFY, That I attended deceased from July 14th, 1930, to July 16th, 1930, that I last saw h— alive on July 16th, 1930, and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Exam

(Signed) Thompson Jones M. D.

19 7/17/30 (Address) 1408 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. — DATE OF BURIAL July 18th 1930

20 UNDERTAKER H. Howard Evans — ADDRESS 38 E. Fort Ave

Spec.—I-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 58838

E 58838

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 17-24 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua Vincent

(a) RESIDENCE NO. 811 Tessier ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Vincent

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Race track work

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Thomas Vincent

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eliza ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of (Address) Balto. City Hospitals

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-15-30

17 I HEREBY CERTIFY, That I attended deceased from 4-22-30, 19..., to 7-15-30, 19..., that I last saw h.. im alive on 7-15-30, 19..., and that death occurred, on the date stated above, at 7:25 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic and acute

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. unknown mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical exam.

(Signed) Dane Padgett, M. D.

7-16, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 7-17 1930

20 UNDERTAKER Daniel D Eaton

ADDRESS 916 Eutaw

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58839

CERTIFICATE OF DEATH.

90 E 58839

REGISTERED NO. 15-63

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Paine

(a) RESIDENCE NO. 4109 Belview Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucille K.

6 DATE OF BIRTH (month, day, and year) Jan. 15, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer) O.K.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alsea Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed ... 19 ... By ... Registrar

7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-15-30

17 I HEREBY CERTIFY, That I attended deceased from 6-24-30, 19..., to 7-15-30, 19...

that I last saw him alive on 7-15-30, 19...,

and that death occurred, on the date stated above, at 4:25 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

marathon (duration) ... yrs. 3 mos ... da.

CONTRIBUTORY (Secondary) Arteriosclerosis and Hypertension (duration) UNKNOWN. yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padget, M. D.

7-16, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 7-17 1930

UNDERTAKER Daniel Easton

ADDRESS 976 Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58840

E 58840

118-02

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1104 N. Payson St. 16-22 Ward)

2-FULL NAME Tom Lazoy

(a) RESIDENCE NO. 1104 N. Payson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 16 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day and year) May 29-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	1	1	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Frank Lazoy

11 BIRTHPLACE OF FATHER (city or town) [illegible]
(State or country)

12 MAIDEN NAME OF MOTHER Ethel Brown

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country) Md

14 Informant ..... (Address) [illegible]

15 Filed ..... 1930 By ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) ....yrs. ....mos. 1 ....ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 7/17 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 302 Pierstmont St

Important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

E 58841

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58841

CERTIFICATE OF DEATH

7-12 199

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospit ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gee Hing

(a) RESIDENCE NO 2228 E. Monument St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	yellow	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	about 40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Resturant Prop.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hoy Ton, China

PARENTS

10 NAME OF FATHER Gee Twong

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Lee Shee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant S.J. Wu,
(Address) 208 W. Fayette St

Filed JUL 7 1930 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of Skull at Base
(Homicide)
(Inquest Later)
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes-Dr. Haldies

What test confirmed diagnosis?

(Signed) J. H. Carter, M. D.
Coroner

7/14/30 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL July 17 1930

UNDERTAKER John F. Denny — ADDRESS 715 Lois et

Spec.—1-30—M. & T.—250 Blks.

E 58842 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58842

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 30 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Flora Wiles.

(a) RESIDENCE NO. Alberton Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 1884

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	45	11	#	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Mary Land

PARENTS

10 NAME OF FATHER William H. Wiles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mary Land.

12 MAIDEN NAME OF MOTHER Dorothy E. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mary Land

14 Informant Sister Rena.
(Address) C. HAMPSON JONES, M. D.

15 Filed ..... 1930 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 7th, 1930, to July 18th, 1930, that I last saw her alive on July 16th, 1930, and that death occurred, on the date stated above, at 2.55 a. m.

The CAUSE OF DEATH* was as follows:

Toxic Psychoses of menopause

(duration) yrs. One mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Laboratory & Clinical findings

(Signed) G. Hill M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ford Shepherd Cem. DATE OF BURIAL July 19 1930.

20 UNDERTAKER Easton Son & Allred ADDRESS Cty

Spec.—1-30—M. & T.—250 Bks.

E 58843 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 58843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Lwer ST. 21-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Magarity

(a) RESIDENCE No. 409 Lyman Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Conway

6 DATE OF BIRTH (month, day, and year) Sept 9 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John S Magarity

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Susanna Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Mrs. Lillie Magarity

(Address) 409 Lyman Ave

15 Filed JAN 7 1930 P. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-16-30

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1930, to July 16, 1930, that I last saw him alive on July 16, 1930 and that death occurred, on the date stated above, at 5 30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate Gland of

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) V Magarity, M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL July 19 1930

20 UNDERTAKER Lila Niedefeld

ADDRESS Greenmount Ave

Spec.—1-12-23—M&T—500 Blks.

E 58844 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58844

51 V

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2214 N Carlton ST., 18-26 WARD)

2-FULL NAME Stella Brown

(a) RESIDENCE NO. 2214 N Carlton ST., 18 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Thomas Brown

6 DATE OF BIRTH (month, day, and year) Sep. 15, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Julius Freeland

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Alice Boltman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) .....

14 Informant Mabel Smith

(Address) 1123 Sarah Ann St

15 Filed JUL 17 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to July 15, 1930, that I last saw h alive on July 14, 1930, and that death occurred, on the date stated above, at 12.25 p m.

The CAUSE OF DEATH was as follows:

Acute Rheumatic Endocarditis

(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? .....

What test confirmed diagnosis? regular

(Signed) W F Rowell MD

July 19 1930 (Address) 601 N Carrollton Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn Cem

DATE OF BURIAL July 19th 1930

UNDERTAKER M A Jones

ADDRESS W E Gilmor

Spec.—1-10-21—M&T—1500 Blks.

E 58845 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58845

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 Bayard St. ST. 21-24 WARD)

2-FULL NAME Annie Rebecca Stiegmann.

(a) RESIDENCE NO. 901 Bayard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Martin Stiegmann

6 DATE OF BIRTH (month, day, and year) Sept 9 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery Co. Md.

PARENTS

10 NAME OF FATHER George William Dove

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Co. Md.

12 MAIDEN NAME OF MOTHER Mary Wilson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montgomery Co. Md.

14 Informant Paul Martin Stiegmann

(Address) 901 Bayard Street

15 Filed JUL 7 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1930

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to July 16, 1930, that I last saw her alive on July 16, 1930, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory, Clinical findings

(Signed) C. Wilbur Stewart, M. D.

7/16 1930 (Address) 1738 E. 28th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL July 19 1930

20 UNDERTAKER Joseph B Cook ADDRESS 1003 N Calvert

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 58846

E 58846 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T. B.) 27-41

CITY OF BALTIMORE: (No. ..... ST. ..... (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Johnson

(a) RESIDENCE NO. 3829 Echodale ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bessie Frazier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address)

15 Filed JUL 17 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1928, to July 17, 1930, that I last saw him alive on July 17, 1930, and that death occurred, on the date stated above, at 5.32 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Lesser, M. D.

7-17, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lynchburg Va

DATE OF BURIAL 7-19-30

UNDERTAKER [illegible]

ADDRESS Lafayette

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58847

E 58847.

CERTIFICATE OF DEATH.

REGISTERED NO. 85

1-PLACE OF DEATH West Baltimore General Hospital ST. 20 28 WARD)

CITY OF BALTIMORE: (NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Barbara Necker

(a) RESIDENCE NO. 2002 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Baldwin Necker

6 DATE OF BIRTH (month, day, and year) June 6, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
66	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs Necker (Address) 642 N. Eutaw St.

15 Filed JUL 17 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1930

17 I HEREBY CERTIFY, That I attended deceased from 6/20/30, 19..., to 7/17/30, 19...,

that I last saw her alive on July sixteenth, 1930,

and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Cataract of the eye - operated - following which slow convalescence began -

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Toxemia + senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 6/21/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles J. Burns, M. D.

, 19 (Address) 812 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL July 19 1930

UNDERTAKER Chas. E. Franck

ADDRESS 802 Madison Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58848 CERTIFICATE OF DEATH. 161-08 E 58848

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1361 N. Gilmore ST. (or WARD) 15-26

2-FULL NAME Baby boy Warfield

(a) RESIDENCE NO. 1361 N. Gilmore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 40 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or estahlishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Elijh Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mary Warfield
(Address) .....

15 Filed JUL 17 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/13/1930

17 I HEREBY CERTIFY, That I attended deceased from 7/13/1930 to 7/13/1930 that I last saw him alive on July 13, 1930, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity (30 wks)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Maternal Lues

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Plasmodium vivax

(Signed) Louis H. Douglass, M. D.

7/15 1930 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS JUL 17 1930

FOR WM. K. ROSSAL

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

162 ✓

E 58849

E 58849

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1639 N. Carey St ST. 15-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Bailey

(a) **RESIDENCE NO.** 1639 N. Carey St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 15, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1 hour	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Walter Bailey

11 BIRTHPLACE OF FATHER (city or town) N. Hampton (State or country) Virginia

12 MAIDEN NAME OF MOTHER Estella Upshure

13 BIRTHPLACE OF MOTHER (city or town) N. Hampton (State or country) Virginia

14 Informant mother

(Address)

15 Filed JUL 17 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to July 15, 1930, that I last saw him alive on July 15, 1930 and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows: Asphyxia

Intrauterine

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. Alexander Howley, M. D.

, 19 (Address) 1576 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JUL 1 3 1930, 19

UNDERTAKER Commissioner Health.

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58850

CERTIFICATE OF DEATH.

161-E 58850

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 58850

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1210 Mc Culloh St. 11-24 WARD)

2-FULL NAME Baby boy Burgess

(a) RESIDENCE NO. 1210 Mc Culloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 15 1930

7 AGE Years ..... Months ..... Days If LESS than 1 day, 3 hrs. or 15 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel Burgess

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Daisy Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Daisy Burgess
(Address) 1210 Mc Culloh St

15 Filed JUL 17 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1930

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to July 15, 1930, that I last saw h[illegible] alive on July 15, 1930, and that death occurred, on the date stated above, at 5.45 P.m.

The CAUSE OF DEATH* was as follows:
Prematurity (28 wks)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] Houghton, M. D.

7/16 1930 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUL 17 1930

20 UNDERTAKER Commissioner W. [illegible]

ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58851

CERTIFICATE OF DEATH

129 ✓ E 58851

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3023 Westwood ave ST., 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jesse H. Hampton

(a) RESIDENCE NO. 3023 Westwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Hester Rawley

6 DATE OF BIRTH (month, day, and year) Dec 30th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ellicott City Md.

PARENTS

10 NAME OF FATHER Jesse Betts Hampton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Marcella Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bessie M. Segerman

(Address) 3023 Westwood ave

15 Filed 1 7 1930 E. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17-1930.

17 I HEREBY CERTIFY, That I attended deceased from July 11th, 1930, to July 16th, 1930 that I last saw him alive on July 16th, 1930 and that death occurred, on the date stated above, at 6. a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis and Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? — —

What test confirmed diagnosis?

(Signed) Isaac E. Dickson, M. D.

July 17. 1930 (Address) 3055 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL July 19 1930

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1946 W. North Ave

Spec.—6-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58852 — REGISTERED NO. 129 E 58852

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. 811 Burgundy ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maggie May Grimm

(a) RESIDENCE NO. 811 Burgundy ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24, 1895

7 AGE — Years 34 | Months 6 | Days 23 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co Md

(State or country)

PARENTS

10 NAME OF FATHER George Grimm

11 BIRTHPLACE OF FATHER (city or town) Hagerstown Co Md

(State or country)

12 MAIDEN NAME OF MOTHER Maud Carter

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Maud Grimm

(Address) 811 Burgundy St

15 Filed 1-17-1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17. 1930

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1929, to July 17, 1930, that I last saw her alive on July 17, 1930, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation of heart and chronic parenchymatous nephritis

(duration) 1 yrs. 3 mos. 25 da.

CONTRIBUTORY (Secondary) General anasarca (duration) yrs. mos. 2 weeks da.

18 Where was disease contracted if not at place of death? — — —

Did an operation precede death? no Date of — — —

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) Jonny Heibel, M. D.

7/17, 1930 (Address) 12 24-1226 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 7/19 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Pond St

Spec.—1-30—M. & T.—250 Blks. Leave at house for Dr Schleider

E 58853

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58853

CERTIFICATE OF DEATH.

129 V

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 93 East ave ST. 76-K WARD)

2-FULL NAME George W. Duncan

(a) RESIDENCE NO. 9 S. East Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena M. Duncan

6 DATE OF BIRTH (month, day, and year) Feb 22, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Newsdealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John H. Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Virginia Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wilmer Duncan (Address) 9 S. East Ave.

15 Filed JUL 17 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 7, 1930, that I last saw him alive on July 7, 1930, and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Myocarditis)

(duration) ..... yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ..... No

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Microscopic

(Signed) Wm Schneider M. D.

7/17 1930 (Address) 3307 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL 7/19/1930

20 UNDERTAKER Wm Cook 1217 St Paul St

ADDRESS

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58854

CERTIFICATE OF DEATH

+ 165 ✓

REGISTERED NO. E 58854

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hosp ST. 75-72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Roemer

(a) RESIDENCE NO Catonsville, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert F. Roemer

6 DATE OF BIRTH (month, day, and year) Dec 12, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	7	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H. W. 37
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry Schanfele

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Clara C Hickman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr. Robert F. Roemer

(Address) Catonsville Md

15 Filed 7-7 1930 HAMILTON JONES, M. D. Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide, - An Overdose of Veronal (150 grains)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Preble, M. D. Coroner

7/17 1930 (Address) 3601 Third Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL July 19 1930

20 UNDERTAKER Geo. W. Little — ADDRESS 1700 Edmondson Ave

TION is very important See instructions on back of certificate

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 58855

58855

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 Valley St. ST. 10-14 WARD)

2-FULL NAME Mary Spicer

(a) RESIDENCE NO. Little Sisters of the Poor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Peru.

PARENTS

10 NAME OF FATHER Thos Spicer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Peru.

12 MAIDEN NAME OF MOTHER Rose McGuire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire.

14 Informant Good Mother (Address) 1200 Valley St

15 Filed 7 17 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/17/30

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to July 17, 1930, that I last saw h.. alive on July 16, 1930, and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wyatt, M. D.

7/17 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL July 18 1930

20 UNDERTAKER Rita Weidefeld — ADDRESS 914 Fremont Ave

Spec.—1-12-23—M&T—500 Bks.

E 58856

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 58856

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Cloverdale Rd 4315 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel P. Johnson

(a) RESIDENCE NO. 1215 Cloverdale Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Johnson

6 DATE OF BIRTH (month, day, and year) 3/5/1889

7 AGE 41

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER John Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Margarete Blundi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant (Address) Grace E. Jackson 1215 Cloverdale Rd

Filed 7-17-1930 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-15-1930

17 I HEREBY CERTIFY, That I attended deceased from 7-10-, 1930, to 7-15-, 1930, that I last saw h[illegible] alive on 7-14-, 1930 and that death occurred, on the date stated above, at 1,30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvulitis and nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) [illegible] yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

7-17-1930 (Address) 611 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemby — DATE OF BURIAL July 18 1930

20 UNDERTAKER Thomas E. Kelsey — ADDRESS 1503 Pennsylvania Ave

Spec.—1-30—M. & T.—250 Blks.

E 58857

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58857

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Lucille Nichols

(a) RESIDENCE NO. Clarke Blvd. Relay Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 28-1927

7 AGE Years	Months	Days	If LESS than 1 day....hrs. or....min.
3	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John W. Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Hattie L. Siemens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. John W. Nichols

(Address) Clarke Blvd Relay Md

15 FILED 1-7 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 16, 1930, that I last saw h.. alive on July 16, 1930, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Peritonitis (general)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 7-12-30

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) George H. Yeager, M. D.

7/16, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk. Cem.

DATE OF BURIAL 7/19, 1930.

20 UNDERTAKER Harry H. Witzke, 4101

ADDRESS Edmondson Ave.

Spec.—1-30—M. & T.—250 Bks

E 58858 HEALTH DEPARTMENT—CITY OF BALTIMORE VE 58858

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2704 Elsinor Ave St. 5-61 WARD)

2-FULL NAME James Lawton Andrews.

(a) RESIDENCE No. 2704 Elsinor Ave ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosalia A. Andrews.

6 DATE OF BIRTH (month, day, and year) July 16, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	81	0	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Youngsville Pa.
(State or country)

PARENTS
10 NAME OF FATHER James Andrews
11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)
12 MAIDEN NAME OF MOTHER Margaret Dills
13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)

14 Informant Mrs. Rosalia A. Andrews
(Address) 2704 Elsinor Ave.

Filed JUL 18 1930 C. HAMPSON JONES, M. D. Registrar
By _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1929, to July 16, 1930, that I last saw him alive on July 16, 1930, and that death occurred, on the date stated above, at 5.15 P m D.S.T. The CAUSE OF DEATH* was as follows:

Carcinoma - Prostate & Bladder

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) _____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Prostate removed 2½ yrs ago

Was there an autopsy? No

What test confirmed diagnosis? Microscopic of removed part

(Signed) M Bamman M. D.

7/22, 1930 (Address) 2216 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL July 19, 30

20 UNDERTAKER Wm J. McKenrick Sons ADDRESS Mt Wilson Pa

Spec.—1-30—M. & T.—250 Blks

E 58859 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58859

91-6

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 Edmondson Ave 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Hollyday

(a) RESIDENCE NO. 1819 Edmondson Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rita Hollyday

6 DATE OF BIRTH (month, day, and year) Jan. 16 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. Ry & Elec. Co.

9 BIRTHPLACE (city or town) Phila. (State or country) Pa.

PARENTS

10 NAME OF FATHER William Hollyday

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louisa Ja Mar Tilghman

13 BIRTHPLACE OF MOTHER (city or town) Hagerstown (State or country) Md

14 Informant Mrs. Lillie M. Berry

(Address) 1819 Edmondson Ave

15 Filed JUL 18 1930 C. H. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1920, to July 16-, 1930,

that I last saw him alive on July 16-, 1930,

and that death occurred, on the date stated above, at 8.05 P. m. Day

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia senile

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) D. E. Burton M. D.

7/18, 1930 (Address) 3018 Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	July 19, 1930
UNDERTAKER Wm J Tucker & Son	ADDRESS North & Pa

Spec.—1-30—M. & T.—250 Blks

E58860 E58860 [redacted]

E58860 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ..... ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Douglas

(a) RESIDENCE NO. 560 W. Mosher ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER George Douglas

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Records of

(Address) Balto. City Hosptials

15 Filed ULT 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-14-30

17 I HEREBY CERTIFY, That I attended deceased from 6-26-30, 19..., to 7-14-30, 19...,

that I last saw him alive on 7-14-30, 19...,

and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute.

Morethon (duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Gangrene of feet (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Howr

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padgett, M. D.

7-15, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft Auburn Cem

DATE OF BURIAL 7-18 1930

20 UNDERTAKER Lottis Bros

ADDRESS 1405 Ashland ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58861

CERTIFICATE OF DEATH

E 58861

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1270 Glyndon Ave St. 21-29 WARD)

2—FULL NAME Michael J. Carroll.

(a) RESIDENCE NO. 1270 Glyndon Ave ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widower.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Molly. Carroll.

6 DATE OF BIRTH (month, day, and year) March 25th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	66.	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buffer.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Balto Tube Co.

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Mary E. Carroll
(Address) 1270 Glyndon Ave.

15 JUL 18 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17th 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 30, to July 16 30, 19.....,
that I last saw him alive on July 16 1930
and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Paralysis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Richard D Dunn M. D.

(Address) 1 E Read St 30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 7. 21 1930

UNDERTAKER John J Cowan & Son

ADDRESS 901 Holbrook

Cor.—10-10-28—A Co.—100 Bks.

E 58862

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58862

CERTIFICATE OF DEATH

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St. 18-N Ward)

2-FULL NAME Wm H. Stahl.

(a) RESIDENCE NO 209 N Schroeder St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Stahl

6 DATE OF BIRTH (month, day and year) July 14 - 1879.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	51		2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cantis
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm Stahl

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Millie Hoffle

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Nettie Stahl
(Address) 209 N Schroeder

15 Filed JUL 18 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. Sudden mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted? If not at place of death? Provident Hosp

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. G. Link, M. D.

July 17 (Address) Cerebral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	7/19/1930
20 UNDERTAKER	ADDRESS
Chas J Cowans & Son	901 Eutaw St

OF DEATH in plain terms, so that it may be understood. Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks. Dr Athey Lombard & Patterson Park

E 58863 HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 58863

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 S. Ann ST., 2-4 WARD)

2-FULL NAME Samuel J Baxter

(a) RESIDENCE NO. 225 S Ann ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Annie M

6 DATE OF BIRTH (month, day, and year) Aug 4 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69	10	11	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel J Baxter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Annie M. Baxter
(Address) 225 S Ann St

15 Filed JUL 18 1930, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 14th, 1930, to the July 16th, 1930, that I last saw him alive on July 14th, 1930, and that death occurred, on the date stated above, at 7 P. m. D.S.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency Chronic
Arteriosclerosis
Broke in Compensation

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Carcinoma Bowel right or rectal

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) Caleb N. Athey, M. D.

July 17, 1930 (Address) 100 S. Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL 7/17 1930

UNDERTAKER Geo Cook

ADDRESS 1218 Pine

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

144 E 58864

E 58864

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Filmore Kinard

(a) RESIDENCE NO. 104 E. Twenty Fifth St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucy C. Kinard

6 DATE OF BIRTH (month, day, and year) Mar. 1 1858

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min.
	72	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Wrightsville Md.

(State or country)

PARENTS

10 NAME OF FATHER Jacob Kinard

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Wint

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant: Lucy C. Kinard

(Address) 104 E. 25th St.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

1 8 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck & knocked down by hit & run driver unapprehended

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract- multiple Ribs Left Side- Ruptd Liver (duration) yrs. mos. ds.

(Signed) G J Cramer M. D. (Coroner)

7/18 1930 (Address) 39 39 W Eds

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

Date of Burial 7/19 1930

UNDERTAKER: Fenn McCully

ADDRESS 130 E. Ford.

Spec.—1-30—M. & T.—250 Blks

E 58865 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58865

CERTIFICATE OF DEATH.

47

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 Brooks Lane ST. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Cooper

(a) RESIDENCE NO. 825 Brooks Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Berman Cooper

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lina Balkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant B Cooper (Address) 825 Brooks Lane

15 7-8-1930 G. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16/30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1929, to July 16 — 1930, that I last saw h alive on July 13 — 1930, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Malignant Adeno-Breast Left

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General Debility

(duration) yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Sept-1929

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) [illegible], M. D.

7/16 1930 (Address) 125 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cemetery — DATE OF BURIAL July 18 1930

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Balto st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58866

CERTIFICATE OF DEATH

15 V

E. 58866

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 S. East Ave ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick a Freier

(a) RESIDENCE NO. 12 S. East Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick Freier

6 DATE OF BIRTH (month, day, and year): March 23, 1850

7 AGE — Years: 80 — Months: 3 — Days: 23 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Frederick Eversmeier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Frederick L. Freier

(Address) 12 S. East

15 Filed 19 Registrar

16 1930

HAMPSON JONES, M. D

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1930, to July 16, 1930, that I last saw h alive on July 16, 1930 and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Sub occipital) Neck

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) General Exhaustion - cc Diarrhea & Heat (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frederick Freier, M. D.

19 (Address) 125 W Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem — DATE OF BURIAL: July 18 1930

20 UNDERTAKER: H. Sander Sons Inc — ADDRESS: 1310 Eutaw St

Spec.—1-30—M. & T.—250 Blks

E 58867 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58867

60-001

CERTIFICATE OF DEATH.

REGISTERED NO. 45-62

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Effie Owen

(a) RESIDENCE NO. 3504 Adardale Rd Balto ST., Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Clarence E Owen

6 DATE OF BIRTH (month, day, and year) July 25-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas A Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co. Md

12 MAIDEN NAME OF MOTHER Willis A Hull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co Md

14 Informant Hospital Records (Address)

15 FILED JUL 18 1930 H. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17-1930.

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 17, 1930, that I last saw her alive on July 17, 1930, and that death occurred, on the date stated above, at 1.25 P m. (EST)

The CAUSE OF DEATH* was as follows:

Hyperthyroidism & Septicemia

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Infected goiter (thyroid)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Washington D.C.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) Harry H Hamsom M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 19th 1930
20 UNDERTAKER	ADDRESS
D. H. Mannix Routson	2235 W North

Spec.—1-30—M. & T.—250 Blks

E 58868 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58868

74001

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2122 Harford Ave ST., 9-46 (WARD)

2-FULL NAME Sarah A. Metter

(a) RESIDENCE NO. 2122 Harford Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 6 mos. 25 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John P. Metter.

6 DATE OF BIRTH (month, day, and year) Dec. 22 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Edward R. Kennick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah A. Austin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Ida Huber
(Address) 2122 Harford Ave

15 Filed JUL 18 1930 C. HAMPSON JONES, M. D. Registrar Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1929, to July 17, 1930, that I last saw h alive on July 15, 1930, and that death occurred, on the date stated above, at 12.20 P m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) ..... yrs. 8 mos 18 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jacob Fisher, M. D.

7/18, 1930 (Address) 1823 N. Haselt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL July 21 1930

20 UNDERTAKER Henry Hoeck Sons Inc — ADDRESS 130 E Eager St

Spec.—1-30—M. & T.—250 Bks

E 58869 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58869

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3313 Edmondson St. 20-10 WARD)

2-FULL NAME Emma Irene Maag

(a) RESIDENCE NO. 3313 Edmondson St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Maag

6 DATE OF BIRTH (month, day, and year) Jan 3rd 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Ed. Belt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Battenfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frederick Maag (Address) 3313 Edmondson Ave

15 Filed JUL 18 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1930

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1930, to July 17, 1930, that I last saw h.. alive on July 16, 1930, and that death occurred, on the date stated above, at 3:15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Ovarian Hypertrophy

Did an operation precede death? No Date of

Was there an autopsy? Yes What test confirmed diagnosis? Clinical

(Signed) A. [illegible] M. D.

(Address) 7/19/30 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 7/19/1930

UNDERTAKER By Jos. Kelly & Son ADDRESS 2503 Edmondson Ave

Spec.—1-30—M. & T.—250 Blks.

E 58870 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 58870

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1028 Argyle Ave (St.) (WARD) 7-24

2-FULL NAME Julia E. Bell

(a) RESIDENCE NO. 1028 Argyle Ave St. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Frederick Bell

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Francis A Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Frederick Bell
(Address) 1028 Argyle Ave

Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15-30

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to July 15, 1930, that I last saw h.r alive on July 15, 1930, and that death occurred, on the date stated above, at 9-45 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 2 mos ..... da.

CONTRIBUTORY (Secondary) Valvular disease of Heart

(duration) ..... yrs. ..... mos. 5 da.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? yes

(Signed) [illegible], M. D.

19 (Address) 1308 W. North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 16, 1930
20 UNDERTAKER Samuel J. Kennedy	ADDRESS 578 N. Biddle

OVER

Spec.—1-30—M. & T.—250 Bks.

Dr Geo Cross 28 W 25th St
Univ. 0619

58871 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 58871

CERTIFICATE OF DEATH.

164 W

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2631 Oak St ST. 17-5 WARD)

2-FULL NAME Louisa E. Fillmore

(a) RESIDENCE NO. 2631 Oak St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of William V.

6 DATE OF BIRTH (month, day, and year) Feb 1st 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co.

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant Emma V. Leffler

(Address) 2631 Oak St

15 Filed JUL 18 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 3rd, 1930, to July 17th, 1930, that I last saw h. alive on July 17th, 1930, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Senile Pneumonia

(durstion) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac sclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George H. Cross, M. D.

, 19 (Address) 28 W 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL 7/21/30

UNDERTAKER J. Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

Dr Bowrey
414 E. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74001 E 58872

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2200 Greenmount ST. 12-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick H. Gilchrist

(a) RESIDENCE No. 2200 Greenmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Margaret Gilchrist

6 DATE OF BIRTH (month, day, and year) April 10-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Gilchrist

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss A. Gilchrist (Address) 2200 Greenmount

15 Filed 1930 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17-30

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1930, to July 17, 1930, that I last saw h. alive on July 17, 1930, and that death occurred, on the date stated above, at 10:50 P.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis — apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Raymond J. Tommy M.D.

7-18-1930 (Address) 414 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 7/21/1930

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul ST

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58873

REGISTERED NO. 1594 E 58873

E 58873

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3109 E. Lafayette St. 6th WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James A. Sanford Sr.

(a) RESIDENCE NO. 3109 E. Lafayette ST. 6th WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13 - 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			5.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. ad

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER James A Sanford Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ella Caudy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant James A Sanford Sr.
(Address) 3109 E. Lafayette Ave

15 Filed 7 18 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/18/1930

17 I HEREBY CERTIFY, That I attended deceased from 7/13, 1930, to 7/18, 1930, that I last saw him alive on 7/18/30, and that death occurred, on the date stated above, at 5.25 A.m.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) David Miller, M. D.

7/18, 1930 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore. DATE OF BURIAL 7/18/1930

20 UNDERTAKER Fred. A. Seale ADDRESS 1500 N Fulton Ave

Spec.—1-30—M. & T.—250 Blks.

E 58874 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58874

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH St Joseph Hospital
CITY OF BALTIMORE, NO. Lafayette & Calvert ST., (WARD) 9-14

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary T. Hamke

(a) RESIDENCE NO. 2705 Tivoly ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of George Hamke

6 DATE OF BIRTH (month, day, and year) Mar 16 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Constant Wess
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Caroline Klein
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Hamke
(Address) 2705 Tivoly ave

Filed JUL 18 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-17th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 7th, 1930, to July 17th, 1930, that I last saw her alive on July 17th, 1930, and that death occurred, on the date stated above, at 5.30 A.m.

The CAUSE OF DEATH* was as follows:

myxoedema

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Chronic Nephritis
with Uremia (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) M. Hundley, M. D.
, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL July 19, 1930

UNDERTAKER Chas. John W. Tenfelde Son — ADDRESS 801 W Fayette

Spec.—2-29-28—L. F. S.—500 Bks.

E 58875

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58875

CERTIFICATE OF DEATH

REGISTERED NO. 57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST., 14-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Philipine Coulson

(a) RESIDENCE NO. 113 S. Calhoun ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Coulson

6 DATE OF BIRTH (month, day, and year) Dec 28 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER John Henkelmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Kath. Sauerbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant John T. Pitts

(Address) 113 S. Calhoun St.

15 Dec. 19 C. HAMPSON JONES, M. D. Registrar

L 1 8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1930, to July 15, 1930, that I last saw h.r alive on July 15, 1930 and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 1 yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What tests confirmed diagnosis? Clinical

(Signed) E. V. Cease, M. D.

19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Redeemer DATE OF BURIAL 7/18/1930

20 UNDERTAKER J. J. Moran ADDRESS E. Baltimore

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 58876

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58876

CERTIFICATE OF DEATH

REGISTERED NO. 91-602

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 S. Ellwood ST. 1st-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George T. Doyle

(a) RESIDENCE NO. 100 S. Ellwood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella V. Doyle

6 DATE OF BIRTH (month, day, and year) Oct 16, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipbuilder

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Marie A. Pitsko

(Address) 100 S. Ellwood

15 Filed JUL 18 1930 19 C. HAMPSON JONES, M. D. (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16-30

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to July 16, 1930, that I last saw him alive on July 15, 1930, and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. E. Long M. D.

(Address) 2711 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL July 19 1930

20 UNDERTAKER Frank V. Pisitano

ADDRESS 2815 E. Baltimore

Spec.—1-30—M. & T.—250 Bks.

E 58877 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58877

162

CERTIFICATE OF DEATH.

REGISTERED NO._____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No.) Caroline ST. 615-21 WARD

2-FULL NAME Baby boy Whittington

(a) RESIDENCE NO. 1833 Clinton ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Royal E. Whittington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER A. Novack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Royal E. Whittington (Address) 1833 Clinton Ave

Filed _____, 19__ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-18-30

17 I HEREBY CERTIFY, That I attended deceased from 7-16-30, 19__, to 7-18-30, 19__,

that I last saw h__ alive on 7-18-30, 19__,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis (duration) __ yrs. __ mos. 3 ds.

CONTRIBUTORY (Secondary) Respiratory Paralysis (duration) __ yrs. __ mos. 1 ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? No Date of _____

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) J. H. Hundley, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Mem. Pk.

DATE OF BURIAL 7/18 1930

20 UNDERTAKER E. Vernon Lemmon

ADDRESS 461 W. Lexington

AUG 6 1930

C. HARRISON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 58878

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58878

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST. ..... WARD .....)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Parzynski

(a) RESIDENCE NO. 1706 Iruyge rd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1-1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Adam Parzynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Frances Koleska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Friends (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 18 1930 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17-1930

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to July 17, 1930, that I last saw him alive on July 17, 1930, and that death occurred, on the date stated above, at 3 35 p m.

The CAUSE OF DEATH* was as follows:

Chronic lobular nephritis

Edema

Myocardial insufficiency

(duration) Years ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Charles M. McLane, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	July 21 1930

20 UNDERTAKER George A. Weber 705 S Ammt ADDRESS

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58879

90 E 58879

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ..... ST. 5-8 ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Watts

(a) RESIDENCE NO. 12 Painters Court ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Oct. 16, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	8	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ellicott City
(State or country) Md.

PARENTS

10 NAME OF FATHER Isaac Watts

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Henrietta ?

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Records of
(Address) Balto. City Hospitals

15 C. HAMPSON JONES, M. D.
Registrar

JUL 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-13-30

17 I HEREBY CERTIFY, That I attended deceased from 1-30-30, 19..., to 7-13-30, 19...,
that I last saw h... im alive on 7-13-30, 19...,
and that death occurred, on the date stated above, at 3:35 A m.

The CAUSE OF DEATH* was as follows:
Myocaydi tis, chronic
+ acute.

More than (duration) ... yrs. 7 mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) ... yrs. unknown mos. ... ds.

18 Where was disease contracted if not at place of death? Home.
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical exam.
(Signed) Paul Padget. M. D.
7-14, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JUL 18 1930

20 UNDERTAKER Commissioner Health.

ADDRESS

For Use of Public

Spec.—1-30—M. & T.—250 Bks.

E 58880 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B. 26-37 WARD) REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST.

2-FULL NAME Ben L. Strange

(a) RESIDENCE NO. Tampa, Florida. ST., WARD (If non-resident give city or town and State)

(Usual place of abode) How long in U. S., If of foreign birth? yrs. mos. ds.

Length of residence in city or town where death occurred yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) April 8, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Daniel Strange

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER Annie Pinner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Florida

14 Informant Hospital Records (Address) JOHNS

15 FILED JUL 18 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1930, to July 14, 1930, that I last saw him alive on July 14, 1930, and that death occurred, on the date stated above, at 7.10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Hus Barnett M.D.

7-14 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 7-16 1930

20 UNDERTAKER Commissioner Health

ADDRESS

By

Spec.—1-12-23—M&T—500 Blks.

E 58881 HEALTH DEPARTMENT—CITY OF BALTIMORE 117 E 58881

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 N Caroll St 18-7th WARD)

2-FULL NAME James E. Presco

(a) RESIDENCE NO. 206 N. Carroll ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary ? 1853

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) George Presco

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Portugal

14 Informant (Address) Joseph Sadler 206 N. Carroll

15 Filed 7/19/1930 19 [illegible] REGISTRAR OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22 1930, to July 16 1930,

that I last saw h[illegible] alive on July 16 1930,

and that death occurred, on the date stated above, at 10-25 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Anemia.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac arteriosclerosis

(duration) yrs. mos. 1/24 da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible], M. D.

7/17 1930 (Address) 11 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery

DATE OF BURIAL 7/19/1930

ADDRESS

UNDERTAKER Jos. G. Kelland

ADDRESS 1631 Druid Hill Ave

2-3-67

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 58882

REGISTERED NO.

E 58882

1-PLACE OF DEATH

City of BALTIMORE: (No. 820 Tyson St. 11-24 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeannette Dennis

(a) RESIDENCE NO. 820 Tyson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Robert Dennis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Rosetta Quinn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Cornelius Dennis

(Address) 820 Tyson St

Filed 1-8-1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1930

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to July 18, 1930, that I last saw h.e alive on July 18, 1930, and that death occurred, on the date stated above, at 3-40 p.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) several yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Edwin R. Ballard M. D.

July 18, 1930 (Address) 1622 N. Royal Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — Date of Burial 7/21/1930

20 UNDERTAKER Wm. Geo. H. Holland — ADDRESS 1631 2 Druid Hill

OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58883

CERTIFICATE OF DEATH.

117

E 58883

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2032 (St.) Ething (Ward) 11-20

2-FULL NAME Lavinia Green

(a) RESIDENCE NO. 2032 Ething ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced — HUSBAND of — WIFE of: Vincent Green

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE: Years 68; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Frederick Co. Md.

PARENTS

10 NAME OF FATHER: Isaac Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Wade

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Lila Harris (Address) 2032 Ething St

15 Filed JUL 18 1930 19..; C. HALSEY JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16/30

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1930, to July 16, 1930, that I last saw h[illegible] alive on July 16, 1930 and that death occurred, on the date stated above, at 1-20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis with rupture and peritonitis

(duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis

(Signed) J. W. Keown, M. D.

7/18/1930 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: July 1930

20 UNDERTAKER: Samuel J. Nemsky

ADDRESS: 1178 W. Baltimore St.

Spec.—1-30—M. & T.—250 Bks.

E 58884 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 58884

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 627 N. Paca St. (WARD) 17-25

2-FULL NAME Hattie Louise Hawkins

(a) RESIDENCE NO. 627 N. Paca ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1892

7 AGE — Years: 38 | Months: 6 | Days: | If LESS than 1 day, ... hrs. or ..... min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer): Apron Maker do

(c) Name of employer: Katzenberg's

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Jas. Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. Md

12 MAIDEN NAME OF MOTHER: Laura Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Myrtle Evans

(Address) 627 N. Paca St.

HARRISON JONES, M.D.

Filed JUL 18 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16/30

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 16, 1930, that I last saw h[illegible] alive on July 16, 1930 and that death occurred, on the date stated above, at 1120 p m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) H. MacMurtrie M. D.

, 19 (Address) 2147 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. DATE OF BURIAL: July 19 30

20 UNDERTAKER: Samuel Hensley ADDRESS: 2138 Eden St

Spec.—1-30—M. & T.—200 Blks

E 58885 HEALTH DEPARTMENT—CITY OF BALTIMORE 104 E 58885

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ..... ST. 22-30 WARD)

2-FULL NAME Lonnie Hill

(a) RESIDENCE NO. 517 W. Lee ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) June 24 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer Iron King Overall Co.

9 BIRTHPLACE (city or town) Norfolk
(State or country) Va.

PARENTS

10 NAME OF FATHER Alfred Hill

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va.

14 Informant Records of
(Address) Balto. City Hospitals

15 [illegible] 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-17-30

17 I HEREBY CERTIFY, That I attended deceased from 7-10-30, 19..... to 7-17-30, 19....., that I last saw h.. alive on 7-17-30, 19....., and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Gangrene of lung.

(duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padgett, M. D.

7-18, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va

DATE OF BURIAL 7-19 1930

UNDERTAKER Daniel Taylor

ADDRESS 516 Eye

Spec.—1-30—M. & T.—250 Bks.

E 58886

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58886

CERTIFICATE OF DEATH.

X 117

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hosp H-30 WARD)

2-FULL NAME Eliza Sydnor

(a) RESIDENCE NO. Walnut Point, Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ or) WIFE of Shelton Sydnor

6 DATE OF BIRTH (month, day, and year) May 5 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	54	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Cornelius Lowry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Laura Fallin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Shelton Sydnor (Address) Walnut Point Va

15 Filed JUL 1 1930 Registrar C. THOMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/8/30

17 I HEREBY CERTIFY, That I attended deceased from 7-9, 1930, to 7-8, 1930, that I last saw her alive on 7-8, 1930, and that death occurred, on the date stated above, at 10 P m. EST.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction.

Sub. acute appendicitis

(duration) ~~3~~ yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pulmonary embolism (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Hosp.

Did an operation precede death? yes. Date of 7-9-30.

Was there an autopsy? yes.

What test confirmed diagnosis? Clin & operative

(Signed) Henry A Wilmer, M. D.

, 19 (Address) Univ Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Walnut Point Va

UNDERTAKER Robert S Sittle

DATE OF BURIAL JUL 19 1930

ADDRESS 2700 EDMONDSON AVE

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58887

E 58887

CERTIFICATE OF DEATH.

74001

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 665 Pierce St. 17-25 Ward)

2-FULL NAME Elizabeth Watts Adams

(a) RESIDENCE NO. 665 Pierce St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Adams

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE — Years: 43 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dress maker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): md

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Watts

11 BIRTHPLACE OF FATHER (city or town): md

(State or country)

12 MAIDEN NAME OF MOTHER: Alberta Hazelton

13 BIRTHPLACE OF MOTHER (city or town): md

(State or country)

14 Informant: Joseph Watts

(Address) 1604 Forman St.

Filed JUL 19 1930, 19____ C. HARRISON JONES, M. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Eugene Talbot, M. D. (Coroner)

7/19, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial: July 20 1930

20 UNDERTAKER: Chas. H. Johnson ADDRESS 4164 N. Carolina Ave

OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 58888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 58888

1—PLACE OF DEATH

REGISTERED NO. 9-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2816 Harford Ave ST. WARD)

2—FULL NAME Annie Elizabeth Poole

(a) RESIDENCE NO. 2816 Harford Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 3 mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward H. Poole

6 DATE OF BIRTH (month, day, and year) Mar 20 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Frederick Tapking

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Kriesemann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edward H. Poole

(Address) 2816 Harford Ave

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

JUL 19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17-30

17 I HEREBY CERTIFY, That I attended deceased from ....., 1920, to July 17, 1930, that I last saw h[illegible] alive on July 14, 1930 and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic febroid tuberculosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Frank Dr. Kahn, M. D.

7/17, 1930 (Address) 3005 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL July 21 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Cor.—10-10-29—A Co.—100 Bks.

E 58889

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58889

90

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1220 Orleans St. (or) 5-8 Ward)

2-FULL NAME Margaret Craig

(a) RESIDENCE NO. 1620 Orleans St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	b	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Noah Craig

6 DATE OF BIRTH (month, day, and year) July 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	67	10		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Wheeler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Moriah Hill

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Arthur J. Smith (Son)
(Address) [illegible] Maryland

JUL 19 1930 C. HUNSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cirrhosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? July 17

What tests confirmed diagnosis? History

(Signed) G. C. Staden, M. D.

19 (Address) 1436 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	July 19 1930
20 UNDERTAKER M. [illegible] Mrs. Thomas H. Bailey	ADDRESS 1426 Jefferson

IMPORTANT. See instructions on back of certificate. DEATH in plain terms, so that it may be properly classified.

Spec.—1-30—M. & T.—250 Bks.

E 58890 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58890

CERTIFICATE OF DEATH.

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 11-16 WARD)

2-FULL NAME Mary E. Gettman.

(a) RESIDENCE NO. 408 N Carey St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Thomas M. Gettman

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pittsburg

(State or country) Pa.

PARENTS

10 NAME OF FATHER James Barrett

11 BIRTHPLACE OF FATHER (city or town) Pittsburg

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Emma Hoffman

13 BIRTHPLACE OF MOTHER (city or town) ------

(State or country) Pa.

14 Informant Mrs. Lillian Kuba

(Address) 331 W. 87th St., New York.

15 Filed JUL 19 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 30th 1930, to July 18th, 1930, that I last saw her alive on July 18th, 1930, and that death occurred, on the date stated above, at 5:35 p m.

The CAUSE OF DEATH* was as follows:

Septic infection of Hand

Diabetes Mellitus - duration unknown -

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) General septicemia -

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of July 2nd.

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture -

(Signed) Geo. Yeager, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 7/23 19 30

UNDERTAKER Henry U. Mears and Son

ADDRESS 805 N. Calvert St.

HALLISON JOHNS, M.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58891

CERTIFICATE OF DEATH

127-081

E 58891

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) West Balto Gen Hosp (Street) 54 (Ward)

2-FULL NAME Charles Wm Snyder

(a) RESIDENCE, NO. 353 W Irvine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sayle

6 DATE OF BIRTH (month, day, and year): 1890

7 AGE: Years 40 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Tire Repairer
(b) General nature of industry, business, or establishment in which employed (or employer): Md Tire Co
(c) Name of employer:

9 BIRTHPLACE (city or town): Va.
(State or country)

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town): [illegible]
(State or country)

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town): [illegible]
(State or country)

14 Informant: [illegible]
(Address) 225 S Linwood

19 [illegible] HAMPSON JONES, M. D.
Registrar

1 9 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Sclerosis of Liver.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible] M. D.

July 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	July 20 1930
20 UNDERTAKER	ADDRESS
Harry H. Dietzhe	4101 Edmondson Ave

OF DEATH in plain terms, so that it may be of value in property transfer. Exact information important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58892

E 58892

CERTIFICATE OF DEATH.

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Quia. Hosp.

CITY OF BALTIMORE: (NO. 43-59 ST. WARD)

2-FULL NAME Leo Metzler

(a) RESIDENCE NO. 2416 Baker ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE Anny Metzler

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing OWN

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jonas Metzler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bonnie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Allen Metzler (Address) 2416 Lakeview Ave

15 Filed JUL 19 1930, 19 By C. HALPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 18, 1930, that I last saw h[illegible] alive on July 18, 1930, and that death occurred, on the date stated above, at 10:5 P. m. EST

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Centuman (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) Melton Brosius, M. D.

, 19 (Address) Quia Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 7/20 1930

20 UNDERTAKER Harid Sondheimer & Son

ADDRESS 1902 Eutaw Place

Spec.—1-30—M. & T.—250 Blks.

E 58893

E 58893 HEALTH DEPARTMENT—CITY OF BALTIMORE

92

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital St. 15-56 (WARD)

2-FULL NAME Louis Hess

(a) RESIDENCE NO. 361 Reisterstown Rd St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE Leah Hess

6 DATE OF BIRTH (month, day, and year) March 4 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paint 045

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Aaron Hess

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Rosa Lowenstein

13 BIRTHPLACE OF MOTHER (City or town) .....
(State or country) Germany

14 Informant Mrs Louis Hess
(Address) 361 Reisterstown Rd.

15 C. HAMPSON JONES, M. D.
Registrar

1 9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1930, to July 16, 1930, that I last saw h alive on July 16, 1930, and that death occurred, on the date stated above, at 10 30 P m. EST

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Milton B. Veroh, M. D.

7-16, 1930 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Beth Shalom Cem	7/29 1930
20 UNDERTAKER Hurd Sondheimer Son	ADDRESS 1902 Eutaw Place

TION IS very important.

Spec.—2-29-28—L. F. S.—500 Blks.

E 58894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 58894

1—PLACE OF DEATH
CITY OF BALTIMORE (No.) 3911 Dorchester Rd St. 5-63 WARD)
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida R Mitchell

(a) RESIDENCE NO. 3911 Dorchester Rd St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dr Charles F Mitchell

6 DATE OF BIRTH (month, day, and year): Sept 16 1857

7 AGE: Years 72 | Months 10 | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in whirh employed (or employer)
(r) Name of employer

9 BIRTHPLACE (City or town) (State or country): Springfield W Va

PARENTS
10 NAME OF FATHER: Parkerson
11 BIRTHPLACE OF FATHER (City or town) (State or country): W Va
12 MAIDEN NAME OF MOTHER: Mary Bradley
13 BIRTHPLACE OF MOTHER (City or town) (State or country): W Va

14 Informant: J Parkerson
(Address) 3911 Dorchester Rd

15 Filed: 1 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1930

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to July 18, 1930, that I last saw her alive on July 18, 1930, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:
Cancer of leg, with general metastases.
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis (duration) yrs. mos. ds.

18 Where was disease rontracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Wesley Cole, M. D.
July 21, 1930 (Address) 220 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jessup Cockeysville Md
DATE OF BURIAL: July 20 30
UNDERTAKER: A S Marshall
ADDRESS: 3539 Fall Rd

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58895

CERTIFICATE OF DEATH

31 E 58895

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1139 N Carey St (ST.) 46-23 (WARD)

2—FULL NAME Ruth Sanger

(a) RESIDENCE NO. 1139 N Carey St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: .....

6 DATE OF BIRTH (month, day, and year): May 4 1908

7 AGE: Years 22 | Months 4 | Days 16 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: College Student

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Tobias Sanger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Elizabeth Sanger

(Address) 1139 Carey St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

JUL 19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17 30

17 I HEREBY CERTIFY, That I attended deceased from July 15 1930, to July 17 1930, that I last saw h.. alive on July 17 1930 and that death occurred, on the date stated above, at 1:30 pm

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. J. Coleman M. D.

19 30 (Address) 2039 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: July 21 1930

20 UNDERTAKER: Harris & Wright — ADDRESS: 720 N Eutaw Ave

Cor.—10-10-29—A Co.—100 Bks.

E 58896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 58896

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2806 Frayl St. 12-51 (Ward)

2-FULL NAME Edward A. Allen

(a) RESIDENCE NO. 2806 Frayl St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residenre in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ann Emma

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) Wash.
(State or country) D. C.

PARENTS

10 NAME OF FATHER Henry Allen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant (Address) Frances Smith 2806 Frayl St.

15 Filed ..... 19..... C. HAMPSON JONES, M. Registrar

JUL 19 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. J. Morrison, M. D.

7/18/30 (Address) 2832 Parkside

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. W. Lawn

DATE OF BURIAL July 21 1930

ADDRESS

20 UNDERTAKER Frank W. Hardy Co. Undertaker

OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 58897.

Kathleen E. Plowman

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58897

CERTIFICATE OF DEATH

117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital, 9-46 Ward)

2-FULL NAME Kathleen E. Plowman

(a) RESIDENCE NO. 718 Homestead St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Aug. 31, 1919

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
10	10	18 17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Stephen M. Plowman

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Simnatt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Father (Address) 718 Homestead St.

15 Filed ..... 19.....

C. HAMPSON JONES, M. D. Registrar

JUL 19 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1930

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquisitory (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquisitory (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Abscess

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dif. Pyrotonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 718 Homestead St

Was operation performed? Yes Date of July 18/30

Was there an autopsy? Yes

What was confirmed diagnosis? Operation

(Signed) J. C. Wades, M. D.

July 19, 1930 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	July 22, 1930
UNDERTAKER Edward W. Conklin	ADDRESS 924 E. Eager St.

OF DEATH in plain terms, so that it may be properly classified. Date statement important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Catherine G. Smith

E 58898 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58898

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2712 Bunard St. 12-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine G. Smith

(a) RESIDENCE. NO. 2712 Bunard St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Milton F. Smith

6 DATE OF BIRTH (month, day, and year) Sept 2, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Annie Cryer

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14 Informant Milton F. Smith
(Address) 2712 Bunard St.

15 Filed JUL 19 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1930

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1930, to July 17, 1930, that I last saw her alive on July 17, 1930, and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Sudden
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. C. Richardson M. D.

July 20 1930 (Address) 117 W. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	July 19 1930

20 UNDERTAKER Ehrenworth Son ADDRESS 3617 Chestnut Ave

CAUSE OF DEATH must be given. See instructions on back of certificates. TION is very important.

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58899

E 58899

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3517 Chesnut Av. 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paulin Dorothea Dennstedt

(a) RESIDENCE NO. 3517 Chesnut Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced
HUSBAND (or) WIFE of Frederick Dennstedt

6 DATE OF BIRTH (month, day, and year) March 25 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Frederick Dennstedt (Address)

15 JUL 19 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1930

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1930, to July 18, 1930, that I last saw her alive on July 18, 1930, and that death occurred, on the date stated above, at 3 15 p m.

The CAUSE OF DEATH* was as follows:

Septic Infection of Hand & Carbo Myo-
Insufficiency

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Injury to Hand + Diabetic Condition

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3517 Chesnut Av

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Chemical

(Signed) Carman, M. D.

7-18-1930 (Address) 1702 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL July 22 1930

20 UNDERTAKER Whitmore — ADDRESS 3417 Chestnut Ave

TION is very important. See instructions on reverse

Spec.—1-30—M. & T.—250 Blks

E 58900

58900 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 ✓

13-52

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3502 Chestnut Ave ST. ..... WARD)

2-FULL NAME Welthy A. A. Frank.

(a) RESIDENCE NO. 3502 Chestnut Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elias J. Frank.

6 DATE OF BIRTH (month, day, and year) May 2, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69.	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 47 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER James Thayer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C.

14 Informant Elias J. Frank.
(Address) 3502 Chestnut Ave

15 JUL 19 1930 C. HAMPSON JONES, Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1930, to July 18, 1930, that I last saw her alive on July 18, 1930, and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) [illegible], M. D.

July 18, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL July 21 1930

20 UNDERTAKER [illegible]

ADDRESS [illegible] Chestnut Ave

TION is very important. See instructions on back

Spec.—8-16-29—L. F. S.—100 Bks.

E 58901

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58901

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1618 Gilmor ST. 15-21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Perry

(a) RESIDENCE NO. 1618 Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Lula Perry

6 DATE OF BIRTH (month, day, and year) Jan 3 - 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jerry Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. C. Brooks (Address) 1529 N. Fulton Ave

15 Filed 1930 H. WILSON JONES, M. D. Registrar.

L 19130

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-17-30

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to July 17, 1930, that I last saw him alive on 7-17-30, and that death occurred, on the date stated above, at 9 PM.

The CAUSE OF DEATH* was as follows:

Renal Dropsy

1 Month

CONTRIBUTORY (Secondary) Acute Nephritis (duration) 1 yrs. 1 Yr. ds.

18 Where was disease contracted if not at place of death? Pennsylvania

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Urinalysis

(Signed) W R Blackiston, M. D.

, 19 (Address) 1512 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Cabery Ct	July 20 1930
20 UNDERTAKER	ADDRESS
W L Brown & Son	108 W. Mosher

Important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58902

E 58902

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave Ward 20-27)

2-FULL NAME Miss Annie McCauley

(a) RESIDENCE NO. Home for the Aged of the M E Church

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 28 1864

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	66	1	19	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore Maryland

(State or country)

PARENTS

10 NAME OF FATHER John McCauley

11 BIRTHPLACE OF FATHER (city or town) Baltimore County Md

(State or country)

12 MAIDEN NAME OF MOTHER Eliza Givens

13 BIRTHPLACE OF MOTHER (city or town) Baltimore County Md

(State or country)

14 Informant Etta Cuddy

(Address) 700 N Fulton Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.

BY .....

JUL 19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1930

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to July 17, 1930, that I last saw h.... alive on July 15, 1930, and that death occurred, on the date stated above, at 1.30a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ✓ yrs. 4 mos. ✓ ds.

CONTRIBUTORY (Secondary) Epilepsy

(duration) 50 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical methods

(Signed) George L. Shannon, M. D.

7/17 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial July 19 1930

20 UNDERTAKER George J Smith ADDRESS 1532 Fallings

OF DEATH in plain terms, so that it may be properly classified. Please write very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58903

E 58903 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90 E 58903

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Aged Women's Home

CITY OF BALTIMORE: (No.) 1404½ E. Lexington St. 14-27 (WARD)

2-FULL NAME Mrs Elizabeth Southard

(a) RESIDENCE No. 1404½ E. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	4 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Martha Baker

(Address) 1404½ E. Lexington

15 Filed JUL 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1930, to July 19, 1930, that I last saw h[illegible] alive on July 17, 1930, and that death occurred, on the date stated above, at 4 35 A. m.

The CAUSE OF DEATH* was as follows:

Heart disease

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Infirmities of age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Duncan, M. D.

, 19 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet — DATE OF BURIAL July 21 1930

20 UNDERTAKER George J. Smith — ADDRESS 1532 Hollins

TION is very important. See instructions on

Spec.—8-16-29—L. F. S.—100 Bks.

E 58904 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58904

CERTIFICATE OF DEATH

1—PLACE OF DEATH U.S. Marine Hospital, Balto., Md. REGISTERED NO. 17251

CITY OF BALTIMORE: (No. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter Brannon

(a) RESIDENCE NO. 45 Monument St., ST. Annapolis, Md. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Kimball

6 DATE OF BIRTH (month, day, and year) July 10, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Off. Std. 1/c

(b) General nature of industry, business, or establishment in which employed (or employer) Coast Guard

(c) Name of employer U.S. Government

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Andrew Brannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Emma Fields

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Records, U.S. Marine Hospital (Address) Baltimore, Md.

Filed JUL 19 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to July 19, 1930, that I last saw h im alive on July 19, 1930, and that death occurred, on the date stated above, at 7:00 A m.

The CAUSE OF DEATH* was as follows:

Appendicitis, acute, suppurative

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Ileus, variety & cause undet.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of 7-14-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab. findings

(Signed) W. M. Eaton, M. D.

7/19 1930 (Address) U.S. Marine Hospital, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brewer Hill Cemetery Annapolis	7/21/1930

20 UNDERTAKER Chas. F. Ricks Jr. ADDRESS 1438 McCulloh St.

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58905

E 58905

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 South Chapel gate S. 68-71 WARD)

2-FULL NAME Sarah Harwood Worthington

(a) RESIDENCE NO. above ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
90		✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Annapolis Maryland

PARENTS

10 NAME OF FATHER Rev. George F. Worthington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Harwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) John A. Worthington Berwick Ave Relston Md

15 Filed 7/21 1930 C. HAMPSON JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1930, to July 19, 1930.

that I last saw her alive on July 19, 1930

and that death occurred, on the date stated above, at 8.05 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia (secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) C. M. Heming, M. D.

7/9, 1930 (Address) Catonsville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md. DATE OF BURIAL July 21 1930

20 UNDERTAKER Jos. S. Taylor & Sons. ADDRESS Annapolis Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

1 19 1930

Spec.—2-25-28—L. F. S.—500 Bks.

E 58906

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 58906

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 Ridgely St. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Minnie Muller

(a) RESIDENCE NO. 930 Ridgely ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 4 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~: Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 5- 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Michael Muller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dora Geres

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Michael Muller

(Address) 930 Ridgely St

15 1 9 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1930

17 I HEREBY CERTIFY That I attended deceased from June 27, 1930, to July 18, 1930, that I last saw h alive on July 18 1930 and that death occurred, on the date stated above, at 10 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Epilepsy

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex

(Signed) J. M. Lumpkin, M. D.

July 19 1930 (Address) 340 E Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: July 21 1930

UNDERTAKER: Forsters & Son — ADDRESS: 217 S. Po...

Important. See instructions on back of this certificate.

Spec.—1-30—M. & T.—250 Blu

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58907 CERTIFICATE OF DEATH. X 129 E 58907

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Provident Hosp ST. 14-20 WARD)

2-FULL NAME William Sumler

(a) RESIDENCE NO. Galesville, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oystershucker 049

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer A. A. Co

9 BIRTHPLACE (city or town) (State or country) A. A. Co

PARENTS

10 NAME OF FATHER Edward Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co

12 MAIDEN NAME OF MOTHER Hickman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co

14 Informant (Address) F. A. Hardesty Galesville

15 Filed JUL 19 1930 WM. S. JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/18/30

17 I HEREBY CERTIFY, That I attended deceased from 6-23-30, 19..., to 7/18, 19 30, that I last saw h... alive on 7/18 19 30 and that death occurred, on the date stated above, at 7.55 P m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

Senile Arterio-sclerosis Gangrene

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of 7/18/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) B. F. Jones, M. D.

7/19 19 3 ★Address) B. F. Jones

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Galesville Md. DATE OF BURIAL July 19 19 30

UNDERTAKER F. A. Hardesty ADDRESS Galesville.

ATION is very important. See instructions on back of Certificate

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58908

CERTIFICATE OF DEATH.

75-001

E 58908

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 Park Ave. St.) 14-20 (WARD)

2-FULL NAME Mary S. Walker

(a) RESIDENCE NO. 2061 Park Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Walker

6 DATE OF BIRTH (month, day, and year) Feb 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Home

(b) General nature of industry, business, or establishment in which employed (or employer) ..... old

(c) Name of employer .....

9 BIRTHPLACE (city or town) Winchester Va
(State or country)

PARENTS

10 NAME OF FATHER James Gilkerson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER Eliz Parkins

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Winchester Va

14 Informant Mrs M. F. Spear
(Address) 2061 Park ave

15 Filed ..... 19 ..... C. HAYES JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 30

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 18, 1930, that I last saw her alive on July 9, 1930, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure
secondary to general
arterial sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemiplegia, right

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Vernon H. Norwood M. D.

....., 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waterford Va — DATE OF BURIAL July 20 1930

20 UNDERTAKER Chas E. Franck — ADDRESS 802 Madison ave

JUL 19 1930 C. HAYES JONES, Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. PAR... TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58909

CERTIFICATE OF DEATH.

E 58909

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2110 N Calvert St. (If not in hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Reynolds Finnegan

(Residence in Baltimore: No. 2110 N Calvert St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-(SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1853 (Year)

7-AGE. Last 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country) Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country) Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Stella McNeal

(Address) 2329 N. Calvert St

15- Filed 20 1930, 19.. C. HAMPSON JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH July 18th, 1930. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest/autopsy/inquiry.) thereon and from the evidence obtained by said (Inquest/autopsy/inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

D. F. Kleyy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) C. Hampson Jones M. D. (Coroner.)

July 19, 1930 (Address) 2332 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery, Harford Road — DATE OF BURIAL, July 21, 1930

20-UNDERTAKER Henry W. Jenkins Sons Co. — ADDRESS Orchard & Gittings

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58910

CERTIFICATE OF DEATH

× 38 ✓ E 58910

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH: City of Baltimore. (No.) Hopkins Disp. St., 1622 (Ward)

2-FULL NAME: Arthio Spence

(a) RESIDENCE NO. 1027 N Stricker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single~~, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: Mary Spence

6 DATE OF BIRTH (month, day, and year): 10 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town):
(State or country) Va

PARENTS

10 NAME OF FATHER: Andrew Spence

11 BIRTHPLACE OF FATHER (city or town):
(State or country) Maryland

12 MAIDEN NAME OF MOTHER: Martha Wilder

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) Va

14 Informant: Richard Spence
(Address) 911 Mount St

15 Filed: JUL 20 1930 H. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 192 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Syphilis

6 d (duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Gonorrhoea.

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) H. G. Clark, M. D.

7-17-30 (Address) 1430 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pythian Woods Co Va — DATE OF BURIAL: July 20 1930

20 UNDERTAKER: Virginia A. Brooks — ADDRESS: 1463 N Carey

OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 58911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

qv E 58911

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. S 5-8 WARD)

2-FULL NAME Reva Baelk

(a) RESIDENCE No. 1202 St. Matthew St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Louis Baelk

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jacob Baelk

(Address) 1202 St Matthew St

Filed JUL 20 1930, 19 H. HAMPSON JONES, M. D. Registrar

TION is very important. See instructions on reverse side.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from 6-29, 1930, to 7-18, 1930, that I last saw h[illegible] alive on 7-18, 1930, and that death occurred, on the date stated above, at 8:20 P. m. E.S.T.

The CAUSE OF DEATH* was as follows:

Thrombosis Spinal Cord

(duration) 1 yrs. mos. dys.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) Milton B Kusel, M. D.

7/18, 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 7/20, 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 Eutaw St

Spec.—1-30—M. & T.—250 Blks.

E 58912 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24001 E 58912

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St. 6-9 WARD)

2-FULL NAME Philip Miller

(a) RESIDENCE NO. 1732 E. Balto. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Bessie Miller

6 DATE OF BIRTH (month, day, and year) 1888 ~~1886~~

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Bessie Miller

(Address) 1732 E Balto St

15 Filed JUL 20 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1:30 AM., 1930, to July 19, 1930,

that I last saw him alive on July 19, 1930,

and that death occurred, on the date stated above, at 3:30 A. m. Eastern Stand. Time.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Obs.

(Signed) Milton B. Cursz M. D.

7/19, 1930 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 7/20 1930

20 UNDERTAKER Jack Levin

ADDRESS 1439 E Balto St

TION is very important. See instructions on

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58913 ✓ 44 E 58913

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3966 Falls Road ST. 13552 WARD

2-FULL NAME Jacob H. Bull

(a) RESIDENCE NO. 3966 Falls Road ST., 13 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced; (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Martha V. Bull

6 DATE OF BIRTH (month, day, and year) March 19-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer Poole Eng. & Mch. Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER John Bull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Martha V. Bull
(Address) 3966 Falls Road

15 Filed ... 19 ... C. HALSEY JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18-1930.

17 I HEREBY CERTIFY, That I attended deceased from Oct ..., 1929 ... to June 18, 1930.
that I last saw h... alive on July 13, 1930.
and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia & General carcinomatosis

(duration) 2 yrs. ... mos ... da.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab. findings

(Signed) Francis ... M. D.

7/19. 1930 (Address) 846 W 36th St. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL July 21-1930.

UNDERTAKER Horace F. Burgee — ADDRESS 3631 Falls Road

TION is very important. See instructions on reverse side.

JUL 20 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58914

CERTIFICATE OF DEATH

74-001 E 58914

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2231 E. Biddle ST. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret H. Winter

(a) RESIDENCE NO. 2231 E Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 9-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Jacob Snyder

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not known

14 Informant Mrs J. Simmons

(Address) Monumental Road Lanvale

15 Filed JUL 29 1930 THOMAS JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 18, 1930, that I last saw him alive on July 18, 1930 and that death occurred, on the date stated above, at 10 45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Ellis L. Singenbach, M. D.

7/19 1930 (Address) 613 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL July 21 1930

20 UNDERTAKER Henry Lutz

ADDRESS 1203 N. Broadway

Important. See instructions on reverse side.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58915 | 4th E 58915

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 239 S. Exeter St. WARD) 13-5

2-FULL NAME Solomon Ben Silvermans

(a) RESIDENCE NO. 239 S. Exeter St. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Silvermans

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel Silvermans
(Address) 4907 Reisterstown Rd

Filed JUL 20 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20/30

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1930, to July 20, 1930, that I last saw him alive on July 19, 1930, and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Oesophagus
(duration) yrs. About 6 mos ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Albert Scagnetti, M. D.
, 19 (Address) 244 S Exeter ST

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mahrs Memorial Cem	July 20, 1930
UNDERTAKER	ADDRESS
Jack Levis 1439	E Balt St

TION is very important. See instructions on back

Spec.—1-30—M. & T.—250 Bks.

58916 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58916

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary DeHaven

(a) RESIDENCE NO. Abingdon Harford Co. St., Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 32 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of or) WIFE of Edward DeHaven

6 DATE OF BIRTH (month, day, and year) Feb 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Leight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edward DeHaven

(Address) Abingdon Md.

15 Filed JUL 20 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1930, to July 19th, 1930, that I last saw h[illegible] alive on July 19th, 1930, and that death occurred, on the date stated above, at 8:40 P. m.

The CAUSE OF DEATH* was as follows:

Cyclitis

(duration) yrs. mos 26 ds.

CONTRIBUTORY (Secondary) Edema of Brain.

(duration) yrs. mos. 014 ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory find. Cytologic examination

(Signed) Henry D. Lincoln, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Abingdon M. E. Cemetery

DATE OF BURIAL July 23 1930

20 UNDERTAKER H. C. McComas

ADDRESS Abingdon Md

TION is very important. See instructions on back

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58917

16-002 E 58917

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp ST. 12-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Ernest Schaefer, Jr

(a) RESIDENCE NO. 934 Greenmount ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 17, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER James E. Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Estelle Litz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James E. Schaeffer Jr (Address) 934 Greenmount Ave

15 Filed JUL 20 1930 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1930

17

I HEREBY CERTIFY, That I attended deceased from July 16th, 1930, to July 19th, 1930, that I last saw him alive on July 19th, 1930, and that death occurred, on the date stated above, at 10:50 a.m. Daylight Time

The CAUSE OF DEATH* was as follows:

Dysentery (ileo-colitis)

ovw

(duration) 0 yrs. 0 mos 9 ds.

CONTRIBUTORY (Secondary) None

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Residence (?)

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? clinical history + culture of stool +

(Signed) Jesse S. Fiser, M. D.

July 19th 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL July 22 1930

20 UNDERTAKER Jos Joerdens & Son

ADDRESS 2173 Pac...

TION is very important. See instructions on back of ...

Spec.—2-29-28—L. F. S.—500 Bks.

E 58918 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 24 E 58918

REGISTERED NO. 9-45

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paul Kriejk

(a) RESIDENCE NO. Oberle Ave - Stemmers Run ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	4	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 0410
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Glen Morton Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Kriejk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Kratz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Schneider (uncle)
(Address) Stemmers Run

15 Filed JUL 20 1930 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1930, to July 19, 1930, that I last saw h.. alive on July 19, 1930 and that death occurred, on the date stated above, at 11 55 p. m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningitis (Meningococcic)

(duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) Myron G. Tull, M. D.

7/20, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 7/21 1930

UNDERTAKER Wm. Cook

ADDRESS 1214 Paul St

Important. See instructions on back of Certificate.

Spec.—1-30—M. & T.—250 Blks.

E 58919 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58919

CERTIFICATE OF DEATH.

REGISTERED NO. 88

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Otto Schilling.

(a) RESIDENCE NO. 3002 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced, HUSBAND of or) WIFE of Anna L. Schilling

6 DATE OF BIRTH (month, day, and year) July 13 1859

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Auditor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Heinz Co Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER William L. Schilling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Anna Stuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Elizabeth Schilling

(Address) 3002 Barclay St

15 Filed JUL 20 1930 C. HALL JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 17th, 1930, to July 18th, 1930, that I last saw him alive on July 18th, 1930, and that death occurred, on the date stated above, at 2.40 p.m.

The CAUSE OF DEATH* was as follows:

General septicaemia

(duration) yrs. mos 4 or 5 ds.

CONTRIBUTORY (Secondary) Endocarditis-acute?

(duration) yrs. mos. 4 or 5 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Procedures and clinical study

(Signed) Geo. Hill. M. D.

7/18, 1930 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL July 21 1930

20 UNDERTAKER Wm H D Cook

ADDRESS 1003 W. Balto

TION is very important. See instructions on back of

Spec.—1-30—M. & T.—250 Blks

E 58920 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58920

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO. ____ ST. ____ WARD) 8-17

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret W. Small.

(a) RESIDENCE NO. 1772 E. North Ave. ST., ____ WARD ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of WILLIAM S. SMALL UNKNOWN.

6 DATE OF BIRTH (month, day, and year) UNKNOWN

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
ABT. 76?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

PARENTS

10 NAME OF FATHER SAMUEL HOLLAND UNKNOWN.

11 BIRTHPLACE OF FATHER (City or town) MARYLAND (State or country) UNKNOWN.

12 MAIDEN NAME OF MOTHER ELIZABETH UNKNOWN

13 BIRTHPLACE OF MOTHER (city or town) MARYLAND (State or country) UNKNOWN.

14 Informant Records (Address) BALTIMORE CITY HOSPITALS

15 Filed JUL 20 1930 19 HARPER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1930.

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to July 19, 1930, that I last saw h alive on July 19, 1930, and that death occurred, on the date stated above, at 11:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) 4 yrs. ____ mos ____ da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) UNKNOWN yrs. ____ mos. ____ da.

18 Where was disease contracted if not at place of death? Hospital (almshouse)

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Paul Padget, M. D.

July 20, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL LOUDON PARK CEMETERY

UNDERTAKER Joseph B Cook

DATE OF BURIAL July, 21 1930

ADDRESS 1003 W. Balto

TION is very important. See instructions on back of Certificate

Cor.—10-10-29—A Co.—100 Blks.

E 58921

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 58921

CERTIFICATE OF DEATH

REGISTERED NO. [redacted]

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Hopkins

City of Baltimore (No. Johns Hopkins Hospital) (Ward) 9

2-FULL NAME Carson King

(a) RESIDENCE NO. Taylorsville Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 5 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, ~~Married~~, ~~Widowed~~ or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 9 1921

7 AGE: 9 Years | Months: 4 | Days: 10 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer

9 BIRTHPLACE (city or town) Taylorsville
(State or country) Md.

PARENTS

10 NAME OF FATHER Stanley Frazier

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Maggie King

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Maggie King
(Address) Taylorsville Md

Filed ... 19... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul T.B.

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did operation precede death? — Date of —

Was there an autopsy? Yes

What confirmed diagnosis? Exam

July 20 1930

(Signed) G. Hampson Jones, M. D.

. 19 (Address) 1436 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brooklyn Grove md

DATE OF BURIAL ... 19

20 UNDERTAKER: Roy W Barbour Baltimore

ADDRESS

JUL 20 1930

For ...

Do not abbreviate. Write in ink, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

✓ E-58922

E 58922

HEALTH DEPARTMENT—CITY OF BALTIMORE

X1-001

E [redacted]2

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 14-20 St.) (WARD)

2-FULL NAME Margaret Savoy.

(a) RESIDENCE NO. Cooksville, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 8 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Cooksville

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Savoy

11 BIRTHPLACE OF FATHER (city or town) Carroll Cty.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Lily Dorsey

13 BIRTHPLACE OF MOTHER (city or town) Cooksville.

(State or country) Md.

14 Informant Wm. Savoy

(Address) Cooksville Md.

15 Filed [illegible] 1930 C. HARRISON JONES, M. D. Registrar

Del

L 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to July 19, 1930, that I last saw h[illegible] alive on July 19, 1930, and that death occurred, on the date stated above, at 3:10 p.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Typhoid

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Conrad M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cooksville Md | DATE OF BURIAL 22 1930

20 UNDERTAKER Wm. Low Sons | ADDRESS Laytonsville Md

TION is very important. See instructions on back of

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 E 58923

58923

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1427 N. Bruce St. 15-21 Ward)

2-FULL NAME Richard Briscoe

(a) RESIDENCE NO. 1427 N Bruce St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male.	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) Sept 20-1890

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	39	9	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) St Mary Co.
(State or country)

PARENTS

10 NAME OF FATHER Romayne Briscoe

11 BIRTHPLACE OF FATHER (city or town) St Mary Co.
(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Curtis

13 BIRTHPLACE OF MOTHER (city or town) St Mary Co.
(State or country) Md

14 Informant Romayne Briscoe
(Address) 1361 Lemmon

15 Filed ..... C. HAMPSON JONES, M. D., Registrar
By .....

F 2 11930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Regulos

(Signed) Chas Funk, M. D.

July 18th (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery — DATE OF BURIAL July 21, 30

20 UNDERTAKER Thomas E. Kelson — ADDRESS 130 Preston St

Now should be carefully examined that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59-002

58924

CERTIFICATE OF DEATH.

E 58924

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. ST. 15-21 WARD)

2-FULL NAME Irene Ruth Lee.

(a) RESIDENCE No. 1729 N. Payson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20-29

7 AGE — Years: 10 Months: 10 Days: 20 If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Marvin Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Dorothy Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Marvin Lee

(Address) 1729 N. Payson St.

15 Filed JUL 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 30

17 I HEREBY CERTIFY, That I attended deceased from 5-16, 19 30, to 7-20, 19 30, that I last saw h[illegible] alive on 7-20, 19 30, and that death occurred, on the date stated above, at 7 05 a.m. E.S.T.

The CAUSE OF DEATH* was as follows:

Congenital heart disease

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clin. observation

(Signed) Hilton B Kersh, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rodef Sholom — DATE OF BURIAL: July 24, 1930

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E. Baltimore

TION is very important. See instructions on back of certificate.

Spec.—1-36—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58925

CERTIFICATE OF DEATH.

90 E 58925

REGISTERED NO. 28163

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 420 or Academy (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Estelle Clutz

(a) RESIDENCE NO. 420 or Academy ST. Fort. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. dy. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry H. Clutz

6 DATE OF BIRTH (month, day, and year) Apr 4 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Frederick Md.

PARENTS

10 NAME OF FATHER Chas Gilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md.

12 MAIDEN NAME OF MOTHER Harriet Morrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md.

14 Informant Mrs C. Hilbert (Address) 4202 Academy ave

15 Filed JUL 21 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1930

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to July 19, 1930, that I last saw her alive on July 18, 1930, and that death occurred, on the date stated above, at 11:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Contributory

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Obesity & Exhaustion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Clinical Evidence

(Signed) E. B. Emrich, M. D.

7-21 1930 (Address) 4936 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL July 21 1930

20 UNDERTAKER Chenowith Olson — ADDRESS 3613 Chestnut

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

E 58926 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58926

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 14-20 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lee

(a) RESIDENCE NO. 1830 Druid Hill Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Lee

6 DATE OF BIRTH (month, day, and year) June 10, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Probe Maitland

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals

Filed 7-21-1930, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-18-30

17 I HEREBY CERTIFY, That I attended deceased from 3-27-30, 19.., to 7-18-30, 19.., that I last saw h.. alive on 7-18-30, 19.., and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 1. Home. 2. Hospital.

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padget, M. D.

7-19, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lyons Cemetery DATE OF BURIAL July 21-1930

20 UNDERTAKER Lyons Gen. Undertakers ADDRESS 1631 Druid Hill Ave

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58927

CERTIFICATE OF DEATH.

49 E 58927

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3018 Maryland Ave WARD 43

2-FULL NAME Hyman Arthur Schaller

(a) RESIDENCE No. 3018 Mary Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie M Schaller

6 DATE OF BIRTH (month, day, and year) March 9- 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meter Man

(b) General nature of industry, business, or establishment in which employed (or employer) Gas & Elec Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Bernard Schaller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER [illegible] Wheeler

13 BIRTHPLACE OF MOTHER [illegible] or town) (State or country) [illegible]

14 Informant Bessie M Schaller

(Address) 3018 Mary Ave

15 Filed JUL 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1930

17 I HEREBY CERTIFY, That I attended deceased from June 7 1930 to May 18 1930

that I last saw him alive on May 17 1930

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Carcinoma of Pylorus

(duration) 7 yrs. 6 mos [illegible] ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? [illegible] State of

Did an operation precede death? Yes Date of June 7 1930

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W S Gray M. D.

7/19/30 (Address) 6 E N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL 7/21 1930

UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT CONDITION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58928

CERTIFICATE OF DEATH

122-002

E 58928

REGISTERED NO. 24-33

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 462 East Cross ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernst E. Mielke

(a) RESIDENCE NO. 462 East Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Lindner Mielke

6 DATE OF BIRTH (month, day, and year) July, 12" 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	XXX	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanist

(b) Genrral nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer Vaile & Young

9 BIRTHPLACE (city or town) (State or rountry) Germany

PARENTS

10 NAME OF FATHER August Mielke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or rountry) Germany

14 Informant Ernst E. Mielke Jr.

(Address) 462 East Cross St.

15 Filed 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July, 19" 1930

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1930 to July 19, 1930

that I last saw h[illegible] alive on July 19, 1930 12.28 NOON

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsy

(duration) yrs. mos. 2 ds.

18 Where was disease contrarted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signrd) H. B. Campbell, M. D.

July 21, 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. DATE OF BURIAL July 21" 1930

20 UNDERTAKER Joseph B Cook ADDRESS 1003 W Baltimore St

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

58929

HEALTH DEPARTMENT—CITY OF BALTIMORE

58929

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 1-23 WARD)

2-FULL NAME William Washington

(a) RESIDENCE NO. 725 N Pamont ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS
10 NAME OF FATHER George Washington
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER Samuel McClay
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ..... C. HARRISON JONES, M. D. Registrar

OCT 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-18-30

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 18, 1930,
that I last saw him alive on July 18, 1930,
and that death occurred, on the date stated above, at 8:30 P.m.

The CAUSE OF DEATH* was as follows:
Coronary Bronchopneumonia
(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Clinical & autopsy
(Signed) Carroll M St Clair, M.D.
, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	July 21 1930
UNDERTAKER	ADDRESS
Samuel Hawkins	Dallas

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

E 58930

CERTIFICATE OF DEATH

E 58930

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 3244 Barclay St., 12-50 (Ward)

2-FULL NAME DeLois E. Barrett

(a) RESIDENCE NO. 3244 Barclay St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April-9-1930

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
		3	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm Curtis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Corine Barrett

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Corine Barrett
(Address) 3244 Barclay St

15 Filed ..., 19.. J. Harold Jones, M. D. Registrar

Per ...

JUL 21 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY
(Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed) John Monroe, M. D.

19 (Address) 2223 Rockrun

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Pleasant Rest

DATE OF BURIAL July 22 1930

20 UNDERTAKER Samuel Kennedy Estate

ADDRESS

tion should be carefully supplied. Age should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58931

E 58931

CERTIFICATE OF DEATH.

× 51

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2311 Aisquith ST., 9-4 WARD)

2-FULL NAME Robert Gillett

(a) RESIDENCE NO. 2311 Aisquith ST., WARD Clearmont

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harrington Del

PARENTS

10 NAME OF FATHER Oscar Gillett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Nelia Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Nelia Gillett (Address) 2311 Aisquith St

15 Filed JUL 21 1930 H. Hampton JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930 to July 20 1930

that I last saw h... alive on July 20 1930

and that death occurred, on the date stated above at 4 p. m.

The CAUSE OF DEATH* was as follows: Endocarditis Lenta (Rheumatic)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

7-21-30 (Address) 806 N Aug Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrington Del

DATE OF BURIAL July 22 1930

20 UNDERTAKER John Ulrich

ADDRESS 29 E Preston

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 58932 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 58932

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Edgewood Sanitarium 8-40 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E E Henderson

(a) RESIDENCE NO. 3120 Lawnview Ave (WARD)

(Usual place of abode) Edgewood Sanitarium (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 8 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joe Kinnear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eleanor Tighe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Eleanor Henderson
(Address) 3120 Lawnview Ave

15 Filed JUL 21 1930 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to July 20, 1930, that I last saw h[illegible] alive on July 20, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Embolism
Myocarditis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clarence Jones M. D.

July 20, 1930 (Address) 4706 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL July 24, 1930

ADDRESS 2000 Orleans

20 UNDERTAKER John Ellis

CLARENCE JONES, M. D.

See instructions on back of certificate.

TION is very important.

JUL 21 1930

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓

58933
1-PLACE OF DEATH

REGISTERED No. 58933

CITY OF BALTIMORE: (No.) I720 N Collington Ave ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise C Stamm

(a) RESIDENCE NO. I720 N Collington Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6I yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John S Stamm

6 DATE OF BIRTH (month, day, and year) I/20/ I868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
(2)	6I	5	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER William Spielmeier

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant John S Stamm
(Address) I720 N Collington Ave

15 Filed JUL 21 1930 19 C. HALSEY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19/1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 14, 1930, to July 19, 1930, that I last saw h[illegible] alive on July 18, 1930 and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) yrs. 3 mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Jacob Fishel, M. D.
7/21, 1930 (Address) 1823 N. Wash St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL July 22 1930

UNDERTAKER John Ellicott

ADDRESS 2208 Orleans

TION is very important. See instructions on back of certificate

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58934

CERTIFICATE OF DEATH

124 ✓ E. 58934

REGISTERED NO. 9-46

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1644 Montpilier ST., WARD)

2—FULL NAME John M. O'Neil

(a) RESIDENCE NO. 1644 Montpilier ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 3 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret O'Neill

6 DATE OF BIRTH (month, day, and year) Apr 15 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired ✓

(b) General nature of industry, business, or establishment in which employed (or employer) Watchman

(c) Name of employer P. R. R. Co.

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER — O'Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire -

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret O'Neill

(Address) 1644 Montpilier

15 Filed JUL 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-19-30

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to July 19, 1930, that I last saw h alive on July 19, 1930 and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Cachexia - Ca.
Cholecystitis

(duration) Two months yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Age. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Wm. B. Sybert, M. D.

19 (Address) 2802 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL July 22 1930

20 UNDERTAKER John A. Moran — ADDRESS 3000 E. Balto St.

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E. 58935

E 5893[illegible]

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 ✓ File No. E 5893[illegible]

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp ST. 11-24 WARD)

2-FULL NAME Frank A. Carter

(a) RESIDENCE NO. 411 W. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. [illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Ella Carter

6 DATE OF BIRTH (month, day, and year) Apr. 8 - 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer St Mary's Co

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Frank Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Ettie Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ella J. Carter

(Address) 411 W. Biddle St.

15 Filed JUL 21 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18-30

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 18, 1930, that I last saw h[illegible] alive on July 18, 1930, and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix

Intestinal Obstruction

(duration) yrs. mos 10 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of July 18, 1930

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) B Harris M. D.

7/17, 1930 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn Cem

DATE OF BURIAL 7-22, 1930

20 UNDERTAKER Wm H Chase Son

ADDRESS 1400 Mosher

INSTRUCTION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58936

CERTIFICATE OF DEATH.

23 E 58936

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 226 Pine ST. (or WARD) 4th

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alma Smith

(a) RESIDENCE NO. 226 Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 6 - 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Delmas Tyson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Delmas Smith
(Address) 226 N. Pine

15 Filed JUL 21 1930, HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to July 18, 1930,

that I last saw h alive on July 18, 1930,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Nose of the Kidneys

(duration) yrs. 2 mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

7-19-1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 7-22-1930

UNDERTAKER Wm. P. Chase Sons

ADDRESS 1400 Mosher

CHECK ... See instructions on back of certificate. TION is very important.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58937. **CERTIFICATE OF DEATH** 129 ✓ E 58937

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Glenwood Ave. ST. 27-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertie J. Mason.

(a) RESIDENCE NO. 502 Glenwood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Mason

6 DATE OF BIRTH (month, day, and year) Nov. 11 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER Thomas Tucker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Eliz. Pickett.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Samuel Mason.

(Address) 502 Glenwood Ave.

15 Filed JUL 21 1930, 19 HAMPSON JONES, M. D. Registrar

By RLK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1930, to July 18, 1930, that I last saw h.. alive on July 18, 1930 and that death occurred, on the date stated above, at 5.35 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Hyp Blood Pressure
Chr Gl. Nephritis, Chr Myocarditis

(duration) 2+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) S. L. Bishop, M. D.

7/21, 1930 (Address) 521 Shenandoah

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockland, Howard Co. Md.

DATE OF BURIAL (1930) 7/21/30

20 UNDERTAKER C. Vernon Lemmon

ADDRESS 4611 Park Heights Ave.

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58938 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 58938

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland University Hospital

CITY OF BALTIMORE: (NO. H-25 ST. WARD)

2-FULL NAME Virginia Waddell

(a) RESIDENCE NO. 235 Lead-ll ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wildon Waddell

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Bettie Hairston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Wildon Waddell

(Address) 235 Lead-ll ST. M. D.

J. HARRISON JONES, M. D.

JUL 7 1930 Mar Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1930, to July 19, 1930, that I last saw her alive on July 19, 1930, and that death occurred, on the date stated above, at 10 35 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs; miliary, acute

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Meningitis, tubercular

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X ray; examination of fluid of tuberculous

(Signed) R. C. Hudson, M. D.

, 19 (Address) Maryland University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 7-21 1930

20 UNDERTAKER Hand Easter

ADDRESS 916 Pe ave

CAUSE OF DEATH. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

David Gill

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58939

CERTIFICATE OF DEATH

114 E 58939

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 132 W Preston St. 11-24 Ward)

2-FULL NAME David Gill

(a) RESIDENCE NO. 132 W Preston St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	3	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER McKinley Gill

11 BIRTHPLACE OF FATHER (city or town) D. C.
(State or country)

12 MAIDEN NAME OF MOTHER Mattie Johnson

13 BIRTHPLACE OF MOTHER (city or town) D. C.
(State or country)

14 Informant McKinley Gill
(Address) 132 W Preston

15 Filed JUL 21 1930 18 C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Not embalmed

DATE OF BURIAL 7-21 1930

20 UNDERTAKER Dennis Easton & Sons

ADDRESS 916 Eutaw

tion should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58940 161-002 E 58940

CERTIFICATE OF DEATH.

58940

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (NO. Caton & Wilkens Aves 25-72 WARD)

2-FULL NAME Baby Boy Sewell

(a) RESIDENCE NO. 1514-86th St Brooklyn N Y WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male.

4 COLOR OR RACE: white.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-19-30

7 AGE — Years — Months — Days 1 — If LESS than 1 day, hrs. or ..... min. — 24 hours

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Sewell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Schuler (Virgin)

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Wm Sewell (Address) 1514-86th St Brooklyn NY

15 Filed JUL 21 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-20 1930.

17 I HEREBY CERTIFY, That I attended deceased from 7-19, 1930, to 7-20, 1930.

that I last saw him alive on 7-20, 1930;

and that death occurred, on the date stated above, at 5-45 P m. Standard Time

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, complicated by Pneumonia

1 Hrs. (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? .....

(Signed) H. Palmer S Anderson M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Abingdon Md Cemetery — DATE OF BURIAL July 2/1930

20 UNDERTAKER Howard K McComas — ADDRESS Abingdon Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 58941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58941

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3308 Oakfield Ave. WARD) 15-64

2-FULL NAME John Lyddane

(a) RESIDENCE NO. 3308 Oakfield Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 44 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wh.	Widower

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Mary Elizabeth Lyddane

6 DATE OF BIRTH (month, day, and year) [illegible] 23, 1839.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	90	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Doctor ODD

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Rockville, Md.
(State or country)

PARENTS

10 NAME OF FATHER Lawrence Lyddane

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore (U.S.A.)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant H. H. Lyddane
(Address) 3308 Oakfield Ave

15 Filed JUL 21 1930, by C. HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to July 21, 1930, that I last saw h[illegible] alive on July 20, 1930, and that death occurred, on the date stated above, at 5:00 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, chronic interstitial nephritis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Maurice E. Shamer, M. D.

7/21, 1930 (Address) 3200 N. Charles Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Oak Hill Cemetery, DATE OF BURIAL July 23 1930

UNDERTAKER Joseph Fowler Sons, ADDRESS Washington, D. C.

CAUSE OF DEATH. See Instructions on back of certificates.
TION is very important.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58942

E 58942

CERTIFICATE OF DEATH.

135

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 27-41 WARD)

2-FULL NAME Joseph E. Jones

(a) RESIDENCE NO. 4303 Hanford Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married -

5a If married, widowed, or divorced (or) WIFE of Susan Jones

6 DATE OF BIRTH (month, day, and year) Oct 11 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER John Joshua Jones

11 BIRTHPLACE OF FATHER (city or town) Charlestown

(State or country)

12 MAIDEN NAME OF MOTHER Rose Mahon

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.

(State or country)

14 Informant James E. Hamilton

(Address) 2506 E. Hamilton

15 Filed JUL 21 1930 T. Ellwood Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19-30

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 19, 1930, that I last saw h.im alive on July 19, 1930, and that death occurred, on the date stated above, at 950 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Prostatis -

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Uremia - (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7-12-30-

Was there an autopsy? no -

What test confirmed diagnosis? operation -

(Signed) W B Hurdis, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cath Cem

DATE OF BURIAL 7/23 1930

UNDERTAKER Leonard J. Rusch

ADDRESS 6403 Belair

CAUSE OF DEATH IS VERY important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58943

E 58943 HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 58943

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1732 Montpelier ST. 9-46 WARD)

2-FULL NAME Robert M. Wright

(a) RESIDENCE NO. 1732 Montpelier ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret S. Wright

6 DATE OF BIRTH (month, day, and year) Feb 14 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Penna.
(State or country)

PARENTS

10 NAME OF FATHER Paul Wright

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Margaret S. Wright
(Address) 1732 Montpelier St

15 Filed JUL 21 1930 H. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 - 1930

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1930 to July 20 1930,
that I last saw h.. alive on July 20, 1930,
and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. L. Campbell M. D.

7/21 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	July 23 1930
20 UNDERTAKER	ADDRESS
Josiah Lyter	1600 W. Pratt

CAUSE OF DEATH. See instructions on back of certificates. CAUSE OF DEATH IS very important.

Spec.—1-30—M. & T.—250 Bks.

E 58944

2E 8983 58944

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 49

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (WARD) 4-25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.)

2-FULL NAME James Glenn

(a) RESIDENCE NO. 622 W. Fayette St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	unknown

5a If married, widowed, or divorced HUSBAND of or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) June-29-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Countersman in

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Glenn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Martha Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

Filed JUL 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20-1930

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to July 20, 1930, that I last saw h alive on July 20, 1930, and that death occurred, on the date stated above, at 6.35 P m.

The CAUSE OF DEATH* was as follows: Carcinoma of adrenals metastases to bowel and liver, pleurisy and Empyema (?)

(duration) 1 (?) yrs. mos ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Fred W Geis, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL July 23 1930

UNDERTAKER Josiah Lyter

ADDRESS 1000 N. Howard

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 58945 90 E 58945

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5513 Norwood Ave ST. 28-64 WARD

2-FULL NAME Henry H. Volke

(a) RESIDENCE NO. 5513 Norwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 - 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hardware Merchant (045)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Christian Volke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henriette Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Volke. (Address) 3702 Chatham road

15 Date received JUL 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15 1930, to July 19 1930.

that I last saw him alive on July 18 1930

and that death occurred, on the date stated above, at 9.25 a m.

The CAUSE OF DEATH* was as follows:

1. Chronic Myocarditis with Myocardial Failure and Pulmonary Embolism

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Hemiplegia, right

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon H. Norwood M. D.

, 19 (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Zion's Cemetery. DATE OF BURIAL July 22 1930.

UNDERTAKER Jos. Mrs. John M. Teufel & Son ADDRESS 601 W. Fayette

mation should be carefully supplied. Any unknown CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58946

CERTIFICATE OF DEATH.

31 E 58946

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital 26-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wiese

(a) RESIDENCE NO. 4205 Stanwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 4 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Checker in Milk Dairy

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Charles Wiese

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Emma Knesith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Anna Hergenroeder

(Address) 4205 Stanwood ave

15 Filed JUL 21 1930 19 HARRY JONES, M. D. City Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1930

17 I HEREBY CERTIFY, That I attended deceased from June 20 1930 to July 18 1930

that I last saw h~~im~~alive on July 18 1930

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs (acute miliary)

(duration) yrs. 3 mos 18 ds.

CONTRIBUTORY (Secondary) Empyema - right side

(duration) yrs. mos. 28 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of June 20 1930

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George Yeager, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 7/22 1930

ADDRESS 3000 E Baltimore

20 UNDERTAKER J. J. Moran

CAUSE OF DEATH must be given. See instructions on back of certificates.

UL 21 1930

Spec.—1-30—M. & T.—250 Blks

E 58947 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 58947

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 26-27 ST. 90 WARD)

2-FULL NAME John Nelson

(a) RESIDENCE NO. none ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	Unknown 74?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Peter Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals

Filed JUL 21 1930 C. HUBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-16-30

17 I HEREBY CERTIFY, That I attended deceased from 1-15-29, 19..., to 7-16-30, 19...,

that I last saw him alive on 7-16-30, 19...,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) 2 yrs. ... mos ... da.

CONTRIBUTORY (Secondary) Parotitis (Not mumps)

(duration) ... yrs. ... mos. 10 da.

18 Where was disease contracted if not at place of death? Home Sudan Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam

(Signed) Paul Padget, M. D.

7-19-1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
UNIVERSITY OF MARYLAND	
20 UNDERTAKER Commissioner Health	ADDRESS JUL 21 1930

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-30—M. & T.—300 Blks.

236734

E 58948

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 58948

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 76-1 ST. WARD)

2-FULL NAME Kenneth Hennel

(a) RESIDENCE No. 1316 S. Highland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June-23-1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Clarence Hennel

11 BIRTHPLACE OF FATHER (city or town) Ill
(State or country)

12 MAIDEN NAME OF MOTHER Jeanette Waters

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 27 1930 19 H. THOMPSON JONES, M. D. Registrar

L 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-21-1930

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to July 21, 1930, that I last saw him alive on July 21, 1930, and that death occurred, on the date stated above, at 3:15 A m.

The CAUSE OF DEATH* was as follows:

Empyema

(duration) yrs. 2 mos 15 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of June 21

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) V. C. Goodwin, M. D.

7/21, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL July 23 1930

20 UNDERTAKER George W. Zinkler

ADDRESS 737 E. Eager st.

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58949

49 E 58949

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 11-24 ST. ..... WARD)

2-FULL NAME James Giles

(a) RESIDENCE NO. 1119 McCulloh ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) July 24, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20 21	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Alonzo Giles

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Lillie ?

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Records of Balto. City Hospitals (Address)

15 Filed JUL 21 1930, 19 H. E. JONES, M. D. Registrar

JUL 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-16-30

17 I HEREBY CERTIFY, That I attended deceased from 4-24-30, 19..., to 7-16-30, 19...,

that I last saw him alive on 7-16-30, 19...,

and that death occurred, on the date stated above, at 6:03 P. m.

The CAUSE OF DEATH* was as follows:

Glioma of Brain.

(duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of July 6, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical, operation.

(Signed) Paul Voight, M. D.

7-19-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUL 21 1930

20 UNDERTAKER Commissioner Health

ADDRESS

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates. TION is very important.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58950

CERTIFICATE OF DEATH

16 1001 58950

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Good Shepherd General Hospital ST. 15-21 WARD) Name

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Infant of Agnes Jones (Wm Jones)

(a) RESIDENCE NO. 1633 Gilmore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months | Days: 12a | If LESS than 1 day, hrs. or min.

7/18/30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Good Shepherd (State or country) General Hospital

PARENTS

10 NAME OF FATHER Colonel Jones

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Agnes Jones

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Colonel Jones

(Address)

15 Filed JUL 21 1930 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19/30

17 I HEREBY CERTIFY, That I attended deceased from July 18 1930 to July 19 1930

that I last saw him alive on 7-19-30

and that death occurred, on the date stated above, at 3 PM

The CAUSE OF DEATH* was as follows:

Premature Delivery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lifting tub of water

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1633 Gilmore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. K. Boyle M. D.

19 (Address) 1512 Gilmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS JUL 21 1930

OF DEATH in plain terms, so that it may be important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 58951 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58951

CERTIFICATE OF DEATH.

X 100-0

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp ST. 14-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hawkins

(a) RESIDENCE NO. Elliott City Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 7. 21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ellicott City Md

PARENTS

10 NAME OF FATHER Geo Hawkins Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ruth Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo. Hawkins (Address) Ellicott City

15 Filed 7 21 1930 C. HAMPSON JONES, M. D. Registrar

CAUSE OF DEATH must be given in plain language. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1930, to July 21, 1930

that I last saw h— alive on July 21, 1930

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

acute Emphysema

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) B Harris, M. D.

7/21, 1930 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ellicott City — DATE OF BURIAL 7-22 1930

20 UNDERTAKER B Hayward Thomas Jr — ADDRESS Ellicott City

Spec.—1-30—M. & T.—250 Bks.

E 38521
E 58952

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 38952

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL ST. 13-59 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Ruth Winston

(a) RESIDENCE NO. 2328 Druid Hill ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	B.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Monroe

6 DATE OF BIRTH (month, day, and year) Aug-11-1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N.W. 837

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chas. P. Brownley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Christine Allen

13 BIRTHPLACE OF MOTHER (city or town) (Srate or country) Va

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 21 1930 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-20-1930

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 20, 1930, that I last saw her alive on July 20, 1930, and that death occurred, on the date stated above, at 2.35 A m.

The CAUSE OF DEATH* was as follows:

Pregnancy 7½ mos Complicated by Toxemia, Syphilis, Diabetes? Bronchopneumonia Nephritis. Kidney abscess

night (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General toxemia

Cerebral Edema (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Charles M. McLane, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL July 23 1930

UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1725 Ashland Ave

CAUSE OF DEATH must be plainly written, so that it can be read in all copies of certificates. See instructions on back of certificates.

L 21 1930

Spec.—1-30—M. & T.—250 Bks.

E 58953

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58953

CERTIFICATE OF DEATH.

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 Myrtle Av. W. 17-24 WARD)

2-FULL NAME Josephine Harris

(a) RESIDENCE NO. 1217 Myrtle Av. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas H. Harris

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER John E. Boseau

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Mary Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Walter Harris

(Address) 1910 Mudeiatus

Filed 7-21-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18/30

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1930 to July 18, 1930

that I last saw her alive on July 18, 1930

and that death occurred, on the date stated above, at 4.27 P.M. E.S.T.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edwin E. Wagstaff M. D.

7/21, 1930 (Address) 1706 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL July 21, 1930

20 UNDERTAKER Mrs R. A. Elliott

ADDRESS 1725 Ashland Ave

CAUSE OF DEATH: In plain terms, so that it can be understood by anyone. See instructions on back of certificates.
TION is very important.

Spec.—1-30—M. & T.—250 Blks.

E 58954 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58954

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 10-14 WARD)

2-FULL NAME Lee Shanks

(a) RESIDENCE NO. 916 Ashland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	B.	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec.-31-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (illegible)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. Car

PARENTS

10 NAME OF FATHER Arthur Shanks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Bernice Pearce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N Car

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

Filed 7-1 1930 C. HAMPSON JONES, M. D., Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-19-1930

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1930 to July 19, 1930, that I last saw him alive on July 19, 1930, and that death occurred, on the date stated above, at 845 P m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

7/20, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL July 21 1930

20 UNDERTAKER Mrs. R. G. Edgerton — ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain words, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58955

CERTIFICATE OF DEATH

+ 111-001

E 58955

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Maryland Gen. Hosp. ST. 14-24 WARD)

2—FULL NAME James Fonwood

(a) RESIDENCE NO. Street, Md. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~wife~~) of Mrs. James Fonwood

6 DATE OF BIRTH (month, day, and year) March 16, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	3 4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Robert Fonwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER Worthington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md.

14 Informant Hospital Records (Address)

15 Filed 21 1930, 19 ... Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1930

17 I HEREBY CERTIFY That I attended deceased from July 15, 1930, to July 21, 1930, that I last saw h~~im~~ alive on July 21, 1930 and that death occurred, on the date stated above, at 2:35 P. m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer & Peritonitis.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Street, Md.

Did an operation precede death? Yes Date of 7/16/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Robert D. Carnett, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thomas Run Cem. Harford Co. Md. DATE OF BURIAL July 24 1930

20 UNDERTAKER B. B. Harle ADDRESS 1000 S. Paca St.

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 58956 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58950

CERTIFICATE OF DEATH.

132

1-PLACE OF DEATH Union Memorial Hospital 12-50 REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. S WARD)

2-FULL NAME Rev. John E. Byers.

(a) RESIDENCE NO. 2900 Guilford Av. Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, ~~Widowed, or Divorced~~ HUSBAND of ~~or WIFE of~~ Virtue E.V. Byers.

6 DATE OF BIRTH (month, day, and year) May 31st 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John. D. Byers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elisa Jane Lantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

Filed JUL 2 1930 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 30th, 1930, to July 20th, 1930, that I last saw h.im alive on July 19th, 1930, and that death occurred, on the date stated above, at 8:20 A m.

The CAUSE OF DEATH* was as follows:

Vesical calculus

(duration) ? yrs. mos da.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 20 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 1st 1930

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) W.F. Cleaveland, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waynesboro Pa. DATE OF BURIAL July 22 19 30

20 UNDERTAKER Stephen Jones and Son ADDRESS 1224 W. Broadway

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate. TION is very important.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58952

E 58952

CERTIFICATE OF DEATH

91-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 729-E-21 St., 9-46 Ward)

2-FULL NAME Paul Byrne

(a) RESIDENCE NO. 729 E 21 St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? 80 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Byrne

6 DATE OF BIRTH (month, day, and year) 7-12-1850

7 AGE	Years	Months	Days	IF LESS (than 1 day) hrs. or min.
	80	7	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Scotland

PARENTS

10 NAME OF FATHER Miles Byrne

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Grant

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Thos. Byrne
(Address) 729 E Oliver St.

15 [illegible] 1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1930

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Senility

Arteriosclerosis

Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. ds.

18 Where did disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? History

(Signed) G. Hampson Jones, M. D.

(Address) 143 N. Duncan

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cremation (Loudon Park)	July 22 19 30
20 UNDERTAKER Thos. M. Medford	ADDRESS 501 E. Fayette

Please be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should see that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should see that information is very important. See instructions on back of certificate. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 58958 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58958

CERTIFICATE OF DEATH. 38

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. St. 7-23 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stacy Dennis

(a) RESIDENCE NO. 704 Brune ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Presser 050

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor shop

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Joshua Dennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lucy Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 7-21, 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-20-30

17 I HEREBY CERTIFY, That I attended deceased from 7-13-30, 19..., to 7-20-30, 19..., that I last saw him alive on 7-20-30, 19..., and that death occurred, on the date stated above, at 6:40 P m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta with aortic insufficiency.

(duration) More than yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia (duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical; Wassermann.

(Signed) Paul Podgel, M. D.

(Address) Balto. City Hosp. 7-21, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (i) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easley S.C.

DATE OF BURIAL July 21, 1930

20 UNDERTAKER Chas. H. Frawley

ADDRESS 598 W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

JUL 21 1930

Spec.—1-30—M. & T.—250 Blks.

2325-98

E 58959

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58950

CERTIFICATE OF DEATH.

70

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. S. 76-1 WARD)

2-FULL NAME Richard Frederick

(a) RESIDENCE NO. 1603 Chilton ST., St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) March-13-30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md — (State or country)

PARENTS

10 NAME OF FATHER Martin Frederick Jr

11 BIRTHPLACE OF FATHER (city or town) Md — (State or country)

12 MAIDEN NAME OF MOTHER Ellanie McCarter

13 BIRTHPLACE OF MOTHER (city or town) Md — (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 21 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20-30

17 I HEREBY CERTIFY, That I attended deceased from 7/1/30, 19 30, to July 20, 19 30, that I last saw him alive on July 20, 19 30, and that death occurred, on the date stated above, at 12 20 P m.

The CAUSE OF DEATH* was as follows:

Brain abscess

(duration) yrs. 2 mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ventro puncture

(Signed) J. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 7/22 1930

20 UNDERTAKER J. F. M. Cully

ADDRESS 130 E Fort

CAUSE OF DEATH in plain terms, so that it may be properly CODED. TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Wilson ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58960

CERTIFICATE OF DEATH.

188-103

E 58960

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Balto. hospital Ward) 24-24

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kenneth Murray Wilson

(a) RESIDENCE NO. 1501 Webster St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15 1926

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	4	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Raymond W. Wilson

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country)

12 MAIDEN NAME OF MOTHER Augusta Steini

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14. Informant W. R. Wilson

(Address) 1501 Webster

Filed JUL 21 1930 G. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows: Run around our auto into park of auto. that struck Kenneth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured skull

(Duration) yrs. mos. ds.

(Signed) H. Hamm M. D.

(Coroner)

7/21 1930 (Address) 2429 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted? (if not at place of death) On front of 520 Patapsco

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	7/22 1930

20 UNDERTAKER J. F. M. Cully ADDRESS 130 S. Fort.

INSTRUCTIONS—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 5896i

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 58961

REGISTERED NO. 15-61

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 Garrison Avenue ST.) (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joanna L. Wherrett

(a) RESIDENCE NO. 2204 Garrison Avenue ST. WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 7 mos. 12 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert M. Wherrett

6 DATE OF BIRTH (month, day, and year) Dec. 9, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER James J. Lacy

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Hurley

12 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penn.

14 Informant Mrs. Jas. P. Devereaux

(Address) 2204 Garrison Avenue

15 Filed L 2 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20-30

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1930, to July 21, 1930, that I last saw h alive on July 21, 1930 and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum with myocarditis (senile) and complications over 2 yrs (duration)

CONTRIBUTORY (Secondary) Shock 4 days death (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Path. Ex.

(Signed) [illegible], M. D.

7/21, 1930 (Address) 2007 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 7/22 1930

ADDRESS

20 UNDERTAKER Henry U. Dears & Son 805 N. Calvert

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58962

E 58962

CERTIFICATE OF DEATH

REGISTERED NO. 46

27-55

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3207 Glen Ave. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME MARGARET M. FREEZE

(a) RESIDENCE NO. 3207 Glen Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas B. Freeze

6 DATE OF BIRTH (month, day, and year) August 10, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John Swann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Gordon White (Daughter)

(Address) 3207 Glen Avenue.

15 Filed JUL 21 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30. 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1930, to July 20th, 1930; that I last saw her alive on July 20th, 1930 and that death occurred, on the date stated above, at 12.50 p. m.

The CAUSE OF DEATH* was as follows: Uterine hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus. (duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) E. B. Shuttenhauck M. D.

7/31, 1930 (Address) 1901 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL July 23 1930

20 UNDERTAKER Henry Sander & Sons. Inc.

ADDRESS Baltimore & Broadway.

IMPORTANT. See instructions on back of certificates. If DEATH in plain terms, so that it may be properly classified.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58963

CERTIFICATE OF DEATH

114 E 58963

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 800 Peirce St., 18-76 Ward)

2-FULL NAME Melvin Williams

(a) RESIDENCE NO. 800 Peirce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 11- 1926

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	3	8	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Warner Williams

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Alice Meyers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Warner Williams
(Address) 800 Peirce St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar.

JUL 21 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1930

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

7/21. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 7-22 1930

20 UNDERTAKER Daniel Eareheart — ADDRESS Balto

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

Snead

E 58964 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58964

CERTIFICATE OF DEATH.

REGISTERED NO. 3

1-PLACE OF DEATH Baltimore City Hospitals (T. B.) ST. 18-26 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Carroll Snead

(a) RESIDENCE NO. 824 W. Franklin st. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Seams Snead

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Laura Bushrod

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address)

15 Filed 7-21 1930 C. HAMPSON JONES, M. D. Registrar By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to July 18, 1930, that I last saw him alive on July 18, 1930, and that death occurred, on the date stated above, at 2.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) David Turner, M. D.

7-18, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carlen Cem

DATE OF BURIAL 7-23 30

ADDRESS 916

20 UNDERTAKER Dennis Eustace

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58965

E 58965

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1817 Dukeland Ave. St. 15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose L. Hush Piggot

(a) Residence No. 1817 Dukeland Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-Single, Married, Widowed, or Divorced: Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Robert Piggot

6-DATE OF BIRTH (month, day and year): Sept. 17- 1881

7-AGE: 48 yrs. 10 mos. 3 ds. | If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Samuel J. Hush

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Alice McCabe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md.

14-Informant: Mrs John Piggot

(Address): 1817 Dukeland Ave

15-Filed ..... 19.. Per ..... Registrar.

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 20. 1930

17- I HEREBY CERTIFY, That I attended deceased from Oct. 29 to July 20. 1930

that I last saw her alive on July 19, 1930

and that death occurred, on the date stated above, at 11.25 A.M

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Toxemia and Exhaustion

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of Aug. 1929

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Mohr M. D

7-21-1930 (Address) 2757 W. North Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park | DATE OF BURIAL: July 22 1930

20-UNDERTAKER: Margaret V. Flynn | ADDRESS: 142 W. Lights St.

L 2 1 1930

Should be carefully examined as to whether it may be properly classified. Exact statement of OCCUPATION is very important in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58966

CERTIFICATE OF DEATH

84 E. 58966

REGISTERED NO. 69

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2566 Edmondson Ave (Street) (Ward) 26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Philip Buettner

(a) RESIDENCE NO. 2566 Edmondson Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Murray Buettner

6 DATE OF BIRTH (month, day, and year): July 11 1879

7 AGE: Years 51 | Months 0 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Constable 186

(b) General nature of industry, business, or establishment in which employed (or employer): People's Court

(c) Name of employer: Balto. City

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Conrad Buettner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Amelia Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Margaret Buettner

(Address) 2566 Edmondson Ave

15 Filed 19 Day C. HAMPSON JONES, M. D. Registrar

L 2 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 23- 19 24, to July 20- 19 1930, that I last saw h[im] alive on July 20- 19 30 and that death occurred, on the date stated above, at 6:50 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hypertension (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) Chester Leland, M. D.

7-20-1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: July 23, 30

20 UNDERTAKER: Margaret E. Flynn — ADDRESS: 2532 Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58967

CERTIFICATE OF DEATH

185 E 53967

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hosp. St., Ward) 1568

2-FULL NAME Morris Stein.

(a) RESIDENCE NO. 2100 Presburry St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. 10 mos. 14 ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) September 7, 1909

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	20	10	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Window dresser.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Max Stein.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Levison.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia.

14 Informant Max Stein. (father)
(Address) 2100 Presburry St.

15 Filed ..... C. HAMPSON JONES, M. D. (Registrar)

JUL 22 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Cervical Vertebrae.
Dove into shallow water.
Occidental Death.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Hawkins Point. July 20, 1930

Did an operation precede death? Yes. Date of July 21, 1930

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Otto Leinhard, M. D.

7/21, 1930 (Address) 1017 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	July 22, 1930
20 UNDERTAKER	ADDRESS
Jack Laws	1439 E. Balto. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. The information called for on this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58968

CERTIFICATE OF DEATH.

REGISTERED NO. E 58968

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 206 S. Caroline St. 3-4 (WARD)

2-FULL NAME Sam Rubin

(a) RESIDENCE No. 206 S. Caroline St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Masha Rubin

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Dave Rubin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel Rubin (Address) 1411 Eutaw Pl.

C. HARRISON JONES, M. D. Registrar

JUL 22 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21-30

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to July 21, 1930, that I last saw him alive on July 21, 1930, and that death occurred, on the date stated above at 3 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death? No Date of

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. J. Boykin M. D.

7/21/30 (Address) 1240 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lehren Rosedale DATE OF BURIAL July 22, 30

UNDERTAKER Jack Lewis ADDRESS 1439 E. Balto

IF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EACH ITEM IS VERY IMPORTANT. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 58969 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-002 E 58969

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 72x Brookwood Rd. 28-6 WARD)

2-FULL NAME Nolan Lee Best

(a) RESIDENCE. No. 72x Brookwood Rd ST., WARD.
(Usual place of above) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Fenton Best

6 DATE OF BIRTH (month, day, and year) April 9. 1871

7 AGE	Years	Months	Days	If LESS than 1 day, brs. or min.
	59	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 009

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Federation Charities

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER James Best

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Narcissa Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Mrs Anna F. Best
(Address) 72x Brookwood Rd

15 Filed JUL 22 1930 C. HAMILTON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15th, 1930, to July 20th, 1930, that I last saw him alive on July 18th, 1930, and that death occurred, on the date stated above, at 4 55 A.m.

The CAUSE OF DEATH* was as follows:

Heart Block

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis with cerebral degeneration (duration) — yrs. 4 mos. ds.

18 Where was disease contracted — if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? yes Hospital

What test confirmed diagnosis? Beginning at Johns Hopkins

(Signed) H. R. Lucien, M. D.

7/30, 1930 (Address) 3921 Edmondson Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	July 22 1930
20 UNDERTAKER J. Frederick Jones	ADDRESS Reta Ave

mation should be carefully supplied. AGE should be stated IMMEDIATELY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58970

CERTIFICATE OF DEATH

E 58970

REGISTERED NO. 49

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 40th St. & Cedar Ave. ST. 13-5K WARD)

2—FULL NAME Mrs. Mary Virginia Leitch (Leitch)

(a) RESIDENCE NO. Home for Incurables ST. 40th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 7 mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of William Leitch

6 DATE OF BIRTH (month, day, and year) Dec. 3-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Farringer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Rebecca Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton Md.

14 Informant Home for Incurables Records (Address) 40th & Leswick Rd.

15 Filed JUL 22 1930 H. M. JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21-1930

17 I HEREBY CERTIFY, That I attended deceased from January 1 19 21 to July 21 19 30

that I last saw h[illegible] alive on July 21 19 30

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Sarcoma (?) of antrum of Highmore

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes — of tumor

What test confirmed diagnosis? Macroscopic exam tumor mass

(Signed) W. H. Brumm M. D.

July 21 19 30 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cem

DATE OF BURIAL July 23 1930

20 UNDERTAKER J. Fletcher Sons

ADDRESS [illegible]

IMPORTANT. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

L 589[illegible]

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58971

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3821 Hayward ave ST. 27-55 (WARD)

2-FULL NAME Mrs Annie E. Kimmy

(a) RESIDENCE NO. 3821 Hayward ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8/ yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Kimmy

6 DATE OF BIRTH (month, day, and year): Nov. 1849

7 AGE: 80 Years; Months 98; Days —; If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 037

(b) General nature of industry, business, or establishment in which employed (or employer): House work

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Martin Weikart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Gertrude Lafayette

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Mrs James Stewart

(Address): 3821 Hayward ave

15 Filed JUL 22 1930 C. HARRISON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 21, 1930, that I last saw her alive on July 21, 1930, and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary): Hart & Kidney trouble

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?: —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & clinical Symptoms

(Signed) C. D. Ensor, M. D.

7-22 1930 (Address) 4936 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

UNDERTAKER: Wilson Cook

DATE OF BURIAL: 7/24 1930

ADDRESS: 1217 Edmondson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 58972 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 58972

CERTIFICATE OF DEATH.

160

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 Cleveland St. WARD) 21-24

2-FULL NAME Leonard J. Curry

(a) RESIDENCE NO. 1201 Cleveland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28th 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Leonard J. Curry

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER Effie Hagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Effie Curry

(Address) 1201 Cleveland St

15 Filed JUL 22 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21st 1930

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1930, to July 21, 1930, that I last saw him alive on July 21, 1930, and that death occurred, on the date stated above, at 8 pm

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) 0 yrs. 7 mos 10 ds.

CONTRIBUTORY (Secondary) Congenital debility from birth

(duration)

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) M. B. Trilinger M.D.

7/21/1930 (Address) 602 Work Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 7/23/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSE TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58973

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 589

1-PLACE OF DEATH St. Joseph's Hospital

CITY OF BALTIMORE: (No. N. Caroline ST. 8-16 WARD)

2-FULL NAME Dorothea Keil

(a) RESIDENCE NO. 1507 N. Luzerne Ave. WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 21st 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Charles Keil

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Emma D. Kraft

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Chas Keil
(Address) 1507 Luzerne Ave

15 Filed JUL 22 1930 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to July 21, 1930, that I last saw her alive on July 21, 1930, and that death occurred, on the date stated above, at 1:10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) W B Hendrix, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL 7/23/1930

UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58974

CERTIFICATE OF DEATH.

143-002

E 58974
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) W. Balt. Gen. Hosp. (St.) 20-69 (WARD)

2-FULL NAME Mrs. Augusta Missbach

(a) RESIDENCE NO. 2822 W. Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles H. Missbach

6 DATE OF BIRTH (month, day, and year): Feb 4, 1891

7 AGE — Years: 39 — Months: 5 — Days: 17 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: August Missbach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Minnie Schopmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles H. Missbach (Address) 2822 W. Mulberry St

15 Filed: L 2 1930 — H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/21/30 19

17 I HEREBY CERTIFY, That I attended deceased from 7/18/30, 19, to 7/21/30, 19, that I last saw h[er] alive on 7/21/30, 19, and that death occurred, on the date stated above, at 8:50 A m.

The CAUSE OF DEATH* was as follows:

ruptured tubal pregnancy

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Colon pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/18/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herbert Meeker, M. D.

19 (Address) W. Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 7/24/1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

IMPORTANT—Should be Literally Supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Cor.—10-10-28—A Co. 100 Blks.

E 58975 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 ✓ E 58975

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 762 Ramsey St. 21-29 Ward)

2-FULL NAME Richard W. Kohlway

(a) RESIDENCE NO. 762 Ramsey St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Kohlway

6 DATE OF BIRTH (month, day, and year) Jan 1-1879

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	51	6	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron Worker
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 29
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Wm. Kohlway

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Stewart

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mary E. Kohlway
(Address) 806 Mangold St

15 Filed 19 C. HARRISON JONES, M. D. Registrar
By

JUL 22 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage due to revolver wound of chest. Suicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Eugene Keller, M. D.

(Signed) Eugene Keller

7/24. 1930 (Address) 739 Eastern Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Anns Cemetery (Annapolis)

DATE OF BURIAL 7/23/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK. 'PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

William J Carey

1-30—M. & T.—100 B—50L

E 58976

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58976

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Bata Ave ST. 24-33 WARD)

2-FULL NAME William J. Carey

(a) RESIDENCE NO Greenland Beach ST., Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6-1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	7	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Const
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm T. Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas Md

12 MAIDEN NAME OF MOTHER Anna E Brady

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto Md

14 Informant Mrs Frank Pellers

(Address) 4015 Piedmont Ave Gardenville

15 Filed JUL 22 1930 19 C. HALL BOZMAN JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Ran from Rear South bound auto and in front side of North bound auto

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Fract skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pneumonia Acute + Catarrh Bronchitis

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Stans Coroner, M. D.

7/24 1930 (Address) 29 39 Md Ave Eldersburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 7/23 1930

UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

mation should be carefully supplied. AGE should be stated EXACTLY. If UNDER ONE DAY, HOURS or MINUTES should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58977

E 58977

CERTIFICATE OF DEATH.

90.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Homewood ST., 9-14 WARD)

2-FULL NAME Isabelle Garet Remsche

(a) RESIDENCE NO. 2005 Homewood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Edw. S. Remsche

6 DATE OF BIRTH (month, day, and year) Aug 5 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84.	11.	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER James Garet.

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Barrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Robt T. Shugars. (Address) 2005 Homewood

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1930

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1930, to July 21, 1930.

That I last saw h[illegible] alive on July 20, 1930, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Cystic degeneration

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical symptoms

(Signed) Albert Singewald, M. D.

7/24 1930 (Address) 1613 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL July 24 1930

20 UNDERTAKER Lewis Cook — ADDRESS 217 N. Paul.

HAMPDEN COPIES, [illegible]

JUL 24 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

Dr Linke No 1717 Caroline St

E 58978 ✓E 58978

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 1633 Harford Ave (ST.) (WARD) 9-18

2-FULL NAME Victoria E. Ely

(a) RESIDENCE NO. 1633 Harford Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widowed
5a If married, widowed, or divorced HUSBAND of or) WIFE of: Enoch Ely
6 DATE OF BIRTH (month, day, and year): Sept. 26 1853
7 AGE: Years 76 Months 4 Days 25 If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country): Md
PARENTS
10 NAME OF FATHER: George Walter
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Emma Dean
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md
14 Informant: Enno Ely (Address) 1633 Harford Ave
15 Filed JUL 22 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-20-30
17 I HEREBY CERTIFY, That I attended deceased from July 20th 1930 to July 20th 1930
that I last saw her alive on July 20th 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency
(duration) yrs. mos 2 ds.
CONTRIBUTORY (Secondary) Infirmity (duration) 5 yrs. mos. ds.
18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms
(Signed) Amelia E. Linke M.D.
7/21, 1930 (Address) 1717 N Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount
DATE OF BURIAL 7/23 30
20 UNDERTAKER: J.M. Cook
ADDRESS 1217 E Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

Dr Wright 1014 S. Ellwood Ave

E 58979

HEALTH DEPARTMENT—CITY OF BALTIMORE

Mech 1688

129 E 58979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1643 Jackson St. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A Bates

(a) RESIDENCE No. 1643 Jackson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John Bates

6 DATE OF BIRTH (month, day, and year): July 19, 1843

7 AGE: Years 87 Months 0 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Akehurst

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Jane Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Jane Brady

(Address) 1643 Jackson St

15 Filed 7/27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from (June) 19 .. to July 24 19 30

that I last saw h.. alive on July 24, 19 30,

and that death occurred, on the date stated above, at 5:15 m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

7 24 19 30 (Address) 1014 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL 7/28 1930

20 UNDERTAKER: W M Cook 1217 — ADDRESS St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

DV Coats
413 N. Wash Pl.
BW 3911

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58980

CERTIFICATE OF DEATH.

74-001

E 58980

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 22 East Lanvale (ST.) 7-19 (WARD)

2-FULL NAME John Phillips

(a) RESIDENCE NO. 22 East Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) ~~WIFE~~ of Margaret Phillips

6 DATE OF BIRTH (month, day, and year) Feb 23-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Passenger Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad Company

(c) Name of employer Railroad Company

9 BIRTHPLACE (city or town) (State or country) Balto County

PARENTS

10 NAME OF FATHER Wm Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant Margaret Phillips

(Address) 22 East Lanvale St

15 Filed JUL 22 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1930

17 I HEREBY CERTIFY, That I attended deceased from March 19 32 to July 20 19 32, that I last saw h.. alive on July 19 19 30, and that death occurred, on the date stated above, at 1.30 P.M. E.S.T.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Davis M. D.

7/21 19 32 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 7/23 1930

20 UNDERTAKER William Coats

ADDRESS 1217 St Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 58981

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58981

CERTIFICATE OF DEATH.

74-66

1-PLACE OF DEATH

City of BALTIMORE: (No. 4804 Park Ave St. 15-66 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J Hall

(a) Residence No. 2706 Presbury St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Theodore F Hall

6-DATE OF BIRTH (month, day and year) 1853

7-AGE. 77 yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer). —

(c) Name of employer. —

9-BIRTHPLACE (city or town) (State or Country), Cambridge Md

PARENTS.

10-NAME OF FATHER, Thomas M. Flint

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Sarah Vickers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

11- (Informant) Wm P. Flint

(Address) 2706 Presbury st

13- Filed ..... 19.. THALHIMER JONES, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 21-30

17- I HEREBY CERTIFY That I attended deceased from July 9 1930 to July 21 1930 that I last saw h.. alive on July 21 1930 and that death occurred, on the date stated above, at 1.55 P.M.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. K. Mellon M. D.

7/31/30 (Address) 2737 E. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cambridge Md

DATE OF BURIAL. 7/22/ 19.30

20-UNDERTAKER. Wm Cook 1217

ADDRESS St Paul st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 22 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 58982

HEALTH DEPARTMENT—CITY OF BALTIMORE E 58982

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2333 Madison ave ST. 12-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Moses Scott

(a) RESIDENCE NO. 2333 Madison ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	c	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Scott,

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ex Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer) Ch

(c) Name of employer 7th Day Adventist Church

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER William Scott

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Fannie Jay

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Julia Brown
(Address) 2233 Madison ave

15 Filed 19 C. HAMPSON JONES, M. D.
Registrar

UUL 22 1930

Entered by Rick

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from December 30, 1929, to July 19, 1930, that I last saw h[illegible] alive on July 19, 1930 and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Age - Arterio Sclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm A Wright, M. D.

July 19, 1930 (Address) 1209 Preston ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 24, 1930

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1422 Eutaw ave

IMPORTANT—Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Statements must be in plain terms, so that it may be properly classified.

Spec.—1-30—M. & T.—250 Bks.

E 58983 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58983

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 6-9 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Washington

(a) RESIDENCE NO. 1609 Orleans St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2-23-08

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
22	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ? (State or country) South Carolina

PARENTS

10 NAME OF FATHER Gus. Washington ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Martha James ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) South Carolina

14 Informant Hosp. Records. (Address) Baltimore City Hosp.

15 Filed JUL 2 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31-30

17 I HEREBY CERTIFY, That I attended deceased from 4-22, 1930, to 7-20, 1930, that I last saw him alive on 7-20, 1930, and that death occurred, on the date stated above, at 4.50 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of 7-8-30

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Fred McDunkum Jr., M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL July 22 1930

20 UNDERTAKER Chas. H. Johnson ADDRESS 46 N. Carolina Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58984

CERTIFICATE OF DEATH

90 E 58984

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1354 W. Stockton St. Ward 15-23)

2-FULL NAME John W. Smith

(a) RESIDENCE NO. 1354 W. Stockton (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE: Years 46 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Robt Smith
11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)
12 MAIDEN NAME OF MOTHER Jane Brooks
13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Lessie Wilson
(Address) 522 Hood

15 Filed ..... 19.. C. HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) H. C. Hampson Coroner, M. D.
July 22 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Marshall Co Va. Wm. Wharf

DATE OF BURIAL July 22, 1930

20 UNDERTAKER Thomas E. Kelso

ADDRESS 1303 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 22 1930

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58935

161-001

CERTIFICATE OF DEATH

REGISTERED NO. E 58935

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1359 N Carey (ST.) 15-23 (WARD)

2—FULL NAME Robert Jones

(a) RESIDENCE NO. 1359 N Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of:

6 DATE OF BIRTH (month, day, and year): July 12 1930

7 AGE: Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Louis Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Alston Md

12 MAIDEN NAME OF MOTHER: Edith Gilbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cary Md

14 Informant: Edith Jones

(Address) 1359 N Carey St

15 Filed 19 Per C. HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 21, 1930,

that I last saw him alive on July 20, 1930

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth 7½ months

Forceps (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature 7½ months

Forceps (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) W H Wright, M. D.

7/21, 1930 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: July 23 1930

UNDERTAKER: Edward L Wright Co

ADDRESS: Baltimore Md

IMPORTANT—Should be carefully supplied. Note instructions on back of certificates. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 22 1930

Spec.—1-30—M. & T.—250 Blks.

235-722 E 58986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

36-005 E 58986

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 16-23 ST. WARD)

2-FULL NAME Charles Gaskins

(a) RESIDENCE NO. 115-S-N. Calhoun ST., 8 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10 NAME OF FATHER Richard Gaskins
11 BIRTHPLACE OF FATHER (city or town) (State or country) La
12 MAIDEN NAME OF MOTHER Isabella Montagne
13 BIRTHPLACE OF MOTHER (city or town) (State or country) La

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 22 1930 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21-30

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1930, to July 21, 1930, that I last saw him alive on July 21, 1930, and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculous Pericarditis with effusion.

(duration) yrs. 5 mos da.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Pericardial paracentesis

(Signed) Hedwig Keeney, M. D.

, 19 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL July 24 1930

UNDERTAKER — ADDRESS

mation should be carefully supplied. Avoid abbreviations. Write plainly in ink. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—200 Blks

Ver 4800

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58987

CERTIFICATE OF DEATH.

E 58987

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp 26-49 WARD)

2-FULL NAME Alice Grover

(a) RESIDENCE No. Belair, Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan 5 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	6	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Belair, Md

PARENTS

10 NAME OF FATHER James Grover

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Frances Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Frances Gordon Grover (Address) Belair

15 Filed JUL 22 1930 C. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21st 1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 21, 1930, that I last saw her alive on July 21st, 1930, and that death occurred, on the date stated above, at 7 Yo p.m. Daylight Time

The CAUSE OF DEATH* was as follows:

Essential cause unknown
Patient was extremely dehydrated and acidotic (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? Belair ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical history

(Signed) Francis W. Gluck, M. D.

7/21, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Chapel M. E. Cemetery — DATE OF BURIAL July 22 1930

20 UNDERTAKER near Belair W. H. Archer — ADDRESS Belair Md

Information should be carefully supplied. AGE should be stated in years. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

Dr Hack 936 E Monument St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58988

CERTIFICATE OF DEATH.

5 E 58988

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5613 (Street) Birchwood Ave (Ward) 27-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna K Ringger Hamilton 5613 Birchwood Ave.

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If ~~married, widowed,~~ or divorced ~~HUSBAND of~~ or) WIFE of Anthony

6 DATE OF BIRTH (month, day, and year) Aug 26th 1871

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
58	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto (State or country) md

PARENTS

10 NAME OF FATHER Chas Waller

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherina Schubard

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Germany

14 Informant George F. Jackson (Address) 5613 Birchwood Ave

15 Filed JUL 22 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21st 1930

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to July 21, 1930, that I last saw h[illegible] alive on July 20, 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Gangrene Both Feet

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) John Patrick M. D.

7-21-1930 (Address) 936 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 7/22/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

mation should be carefully supplied. AGE should be stated. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

58989

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-103

E 58989

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1546 Holbrook St., 9-18 Ward)

2-FULL NAME Elizabeth Fine

(a) RESIDENCE NO. 1546 Holbrook St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Fine

6 DATE OF BIRTH (month, day, and year) March 30 1856

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	74	3	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Schneider

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant John Fine
(Address) Fullerton Md.

15 Widow of 19 C. HARRY JONES, M. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: While running to catch street car ran into path of moving auto

Use (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

Possible Track Shock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fremont & Eighth

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) L. Mann, M. D.

7/21 1930 (Address) 2939 W. Eager

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cemetery	July 23 1930
20 UNDERTAKER	ADDRESS
Fredk Lassahn Sons	Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 22 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58990

CERTIFICATE OF DEATH

91-002

E 58990

1—PLACE OF DEATH The Home for Incurables REGISTERED NO. 77-53

CITY OF BALTIMORE: (No. 40th St. & Cedar ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Ella R. Easter
R. Park

(a) RESIDENCE NO. 6 Boulder Lane ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Stanley Easter

6 DATE OF BIRTH (month, day, and year) 3-12-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER James Rogers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md.

14 Informant Hosp. Record
(Address)

15 Filed JUL 22 1930, 19 C. HAMPSON JONES, M. D.
Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 - 1930

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1930 to July 20, 1930

that I last saw h. alive on July 20 - 1930

and that death occurred, on the date stated above, at 9:10 a.m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) W. W. Mayo M. D.

July 21, 1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem

DATE OF BURIAL July 23 1930

20 UNDERTAKER Henry H. Jenkins Son Co

ADDRESS 711 Gilmor & Orchard St.

IMPORTANT: In filling out this certificate, use ordinary terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58991

CERTIFICATE OF DEATH.

49 ✓ E 58991

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 21-29 ST. WARD)

2-FULL NAME Samuel Crump

(a) RESIDENCE NO. 1222 Ellyndon Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Crump

6 DATE OF BIRTH (month, day, and year) Aug 31, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50 / 51		10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse Shoer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer James Walsh

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Crump ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Mrs. Rupp (Address) Baltimore City Hosp.

15 Filed JUL 22 1930 H. [illegible] JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-19-30

17

I HEREBY CERTIFY, That I attended deceased from 7-2-, 1930, to 7-19-1930, that I last saw him alive on 7-19-, 1930, and that death occurred, on the date stated above, at 11 45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum with local metastases

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Fred M. Brackenridge M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 7/23/1930.

20 UNDERTAKER Frederick U Cole

ADDRESS 1200 W Lanvale St.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 58992 HEALTH DEPARTMENT—CITY OF BALTIMORE E 58992

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 439 E. 28th St 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Williams

(a) RESIDENCE NO. 439 E. 28th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of: late Philip G. Williams

6 DATE OF BIRTH (month, day, and year): Dec 25/54

7 AGE: Years 70 | Months 6 | Days 27 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John F. Simpson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth —

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Md.

14 Informant: Mrs. Wm E. Roberts

(Address) 434 E 28th St

15 Filed JUL 22 1930 H. M. REGISTER JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21/30

17 I HEREBY CERTIFY, That I attended deceased from July, 1925, to July 21, 1930, that I last saw her alive on July 19, 1930, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary): Chr. Nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination + Urinalysis

(Signed) Wm. P. Speight, M. D.

7/21 1930 (Address) 2225 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine — DATE OF BURIAL July 23, 30

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans St

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-30—M. & T.—250 Bks

E 53992

HEALTH DEPARTMENT—CITY OF BALTIMORE

41 E 58993

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 N. Dallas St. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia White

(a) RESIDENCE NO. 1508 N. Dallas ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William White

6 DATE OF BIRTH (month, day, and year) Jan 3 1893

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) Roundaway N.C.
(State or country)

PARENTS

10 NAME OF FATHER Henry Fogdon

11 BIRTHPLACE OF FATHER (city or town) U.S.
(State or country)

12 MAIDEN NAME OF MOTHER Ella Woods

13 BIRTHPLACE OF MOTHER (city or town) U.S.
(State or country)

14 Informant Ella Fogdon
(Address) 1508 N. Dallas St

15 7-22-1930, 19 [illegible] JOHNS, M.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1930

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1930 to July 20, 1930

that I last saw h[illegible] alive on July 19, 1930

and that death occurred, on the date stated above, at 3a. m.

The CAUSE OF DEATH* was as follows: -

Pulmonary (?) T.B.
Intestinal Tuberculosis
about 2 1/2 mos

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. Mayfield Cooke, M. D.

7/21/1930 (Address) 835 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvery

DATE OF BURIAL 7-22 1930

20 UNDERTAKER Byron Wright 1218 N

ADDRESS Eldersley St

mation should be carefully supplied. AGE should be filled in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

58994

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

E 58994

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No. 2211 Baker St., 15-6A Ward)

2-FULL NAME Isaac Shapero

(a) RESIDENCE No. 2211 Baker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena

6 DATE OF BIRTH (month, day, and year): 1855

7 AGE: Years 75 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Fish Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Russia
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Lena Baker
(Address) 2211 Baker

Filed JUL 22 1930 19 H. MADISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. C. [illegible], M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mourning Ex. Balto

DATE OF BURIAL: July 22 19 30

20 UNDERTAKER: Jacob Levin

ADDRESS: 1439 E. Balto St.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58995

CERTIFICATE OF DEATH

129 ✓

E 58995

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1364 N. Calhoun ST. 15-27 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charlotte Clark

(a) RESIDENCE NO. 1364 N. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	(Widowed).

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Clark

6 DATE OF BIRTH (month, day, and year) Aug 12, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salisbury N.C.

PARENTS

10 NAME OF FATHER William Ferrow

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Mona Bolden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Hattie Grant

(Address) 1364 Calhoun St.

15 Filed JUL 22 1930, 19 C. HAMPSON JONES, M. D. Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1930

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1930, to July 19, 1930

that I last saw h e alive on July 19, 1930

and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis & Interstitial Nephritis (duration) yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical - History

(Signed) Wm. H. Wright, M. D.

7/20, 1930 Address) 120 Forrest Ave St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salisbury N. C.	July 22 1930
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1303 Greatman St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 22 1930

Cor.—10-10-29—A Co.—100 Bks.

E 58996

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1930 E 58996

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 21-24 Ward)

2-FULL NAME Nellie Rabinis

(a) RESIDENCE NO. 762 Ramsey St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lithuania

PARENTS

10 NAME OF FATHER Anthony Mazeika

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Anne Lapulis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Chas. Rabinis
(Address) 762 Ramsey St.

15 Filed JUL 22 1930 16 [illegible] JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Revolver wound of head.
Homicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 762 Ramsey St

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

7/22, 1930 (Address) 275 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	July 23 30
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

58997

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1930 E 58997

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 21-29 Ward)

2-FULL NAME Mary Rawnis

(a) RESIDENCE NO. 762 Ramsey St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	18			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER John Rawnis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Nellie Mazeka

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Chas. Rawnis
(Address) 762 Ramsey St

15 Filed ..... 19 ..... H. A. [illegible] JONES, M. D.
Registrar

JUL 22 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage due to revolver wound of abdomen.
Homicide
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 762 Ramsey St
Did an operation precede death? Yes Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Eugene Feller, M. D.
7/22 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudenslager Cem	July 23 1930
20 UNDERTAKER John Grebliauckas	ADDRESS 423 E Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

58998 4 Grands

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179

E 58998

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St. 23-32 Ward)

2-FULL NAME Harry Hoffman.

(a) RESIDENCE NO. 15 N. Barney St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 1 mos. 26 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed~~ or ~~divorced~~ HUSBAND of ~~XXXXXXXXXX~~ Mary A. Hoffman.

6 DATE OF BIRTH (month, day, and year) May 25, 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57	1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Nat. Enaml. & Stmp Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Frederick Hoffman.

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Hannigan.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Mary A. Hoffman. (wife)
(Address) 15 N. Barney St.

15 Filed JUL 22 1930 C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Oedema of the Brain. Terminal Broncho-Pneumonia.

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Trauma to face & eyes.

Sulphuric Acid. Accidental Death (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? Nat. Enaml. & Stmp. Co. July 18, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Leonhardt, M. D.

7/22. 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL 7/24 1930

20 UNDERTAKER J. F. McAuley

ADDRESS 130 E Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-30—M. & T.—100 B—50L

Henry Williams

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 58999

CERTIFICATE OF DEATH

160

E 58999

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 W. Lexington ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Williams

RESIDENCE NO 1523 W. Lexington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sadie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sadie Williams

(Address) 1503 W. Lexington St.

15 Filed JUL 22 1930, 192 HERMAN JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Marasmus & Toxic colitis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooks, M. D. Coroner

7/14 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS JUL 22 1930

THE MORGUE

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59000

CERTIFICATE OF DEATH

90 E 59000

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 887 W Fairmount ST. 18 WARD)

2-FULL NAME Emma Martin

(a) RESIDENCE NO 887 W Fairmount ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant

(Address)

15 Filed JUL 22 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 4 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D. Coroner

7/19 19 30 (Address) 2729 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS JUL 22 193

THE MORGUE.

N.B.—WRITE PLAINLY, WITH PENCIL OR PEN AND INK. AGE should be stated EXACTLY. Information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 2647

City of BALTIMORE: (No. 1436 Argyle Ave. St. or Ward)

2-FULL NAME (not usual name)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1436 Argyle Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1/2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 20, 1930

7 AGE: Years | Months | Days: 1/2 | If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Leroy Benson

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country): S. C.

12 MAIDEN NAME OF MOTHER: Josephine Watson

13 BIRTHPLACE OF MOTHER (city or town): Lynchburg

(State or country): Va.

14 Informant: Leroy Benson

(Address): 1436 Argyle Ave.

15 Filed JUL 22 1930 SOLON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1930

17 I HEREBY CERTIFY, That I attended deceased from July 20 1930 to July 21, 1930, that I last saw her alive on July 21, 1930, and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm H. Watts, M. D.

July 21, 1930 (Address) 928 Penna. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial: 19

20 UNDERTAKER: Commissioner Health. ADDRESS

UNIVERSITY OF MARYLAND JUL 2 1930

Per W. E. WOODALL

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-30—M. & T.—250 Blks.

2 E 56 59002 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. E 59002

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 7-9 WARD)

2-FULL NAME Lossie Daniels

(a) RESIDENCE No. Rocky Mount N.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18-1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Columbus Daniels

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

JUL 22 1930 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21-1930

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1930, to July 21, 1930.

that I last saw him alive on July 21, 1930

and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Gonococcal Arthritis

Gonococcal Septicaemia?

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Hedwig Kopetz, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rocky Mount N C

DATE OF BURIAL 7/21/30

UNDERTAKER Joseph Ahrens

ADDRESS 221 Bway

Spec.—1-30—M. & T.—250 Bks.

59-003 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59003

E 59003

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 24-33 WARD)

2-FULL NAME Dolores Pumphrey

(a) RESIDENCE No. 115 E. Hamburg ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Wm. H. Pumphrey

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Gutbrasan

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Wm. H. Pumphrey
(Address) 115 E. Hamburg St

15 Filed JUL 22 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1930, to July 21, 1930, that I last saw h.... alive on July 21, 1930, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Impetigo Contagiosa

(duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of June 19, 1930

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) George H. Yeager M. D.

7/21, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL July 23 1930

20 UNDERTAKER [illegible]

ADDRESS 703 Hanover

Spec.—8-16-29—L. F. S.—100 Bks.

E 59004 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 59004

90

CERTIFICATE OF DEATH

REGISTERED NO. 24-34

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1605 Webster ST. WARD)

2—FULL NAME Margaret G. Burke

(a) RESIDENCE NO. 1605 Webster ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter J. Burke

6 DATE OF BIRTH (month, day, and year) Feb 9-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wash D. C.

PARENTS

10 NAME OF FATHER John Shea.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret M. Baron

(Address) 1605 Webster st.

15 Filed ....., 19 ..... Registrar

AUG 2 1930 BALTIMORE, MD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929 to July 21, 1930, that I last saw her alive on July 21, 1930 and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Indefinite
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. B. F. Campbell M.D.

7/21 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL July 23, 1930

20 UNDERTAKER Paul P. Schwarzkopf — ADDRESS 703. Hanover st

Coroners Fee for 700 E Chase — Ver 6035 ✓

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

185

E 59005

CERTIFICATE OF DEATH.

E 59005

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgianna Abbott

(a) RESIDENCE NO. 1617 Gough St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If ~~married~~, widowed, or ~~divorced~~ (or) WIFE of: Frederick Abbott

6 DATE OF BIRTH (month, day and year): Feb 11th 1857

7 AGE: Years 73 Months 5 Days 10 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town)

(State or country): Balto Md

10 NAME OF FATHER: John Hughes

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Sarah A Hush

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto Md

PARENTS

14 Informant: Mary Hughes

(Address): 1617 Gough St

15 Filed 7 21 1930 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): July 21st 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to ~~her~~ death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows: Chronic Nephritis Tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture R Leg by falling down stairs

(duration) yrs. mos. ds.

(Signed) James M Hampson M. D. (Coroner)

7 21 30 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death? 1617 Gough St

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — Date of Burial 7/24/1930

20 UNDERTAKER: Wm Cook 1217 St Paul St — ADDRESS

very Important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59006

CERTIFICATE OF DEATH.

145-001 E 59006

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore Gen. Hosp. ST. 27-49 (WARD)

2-FULL NAME Elsie Norton

(a) RESIDENCE NO. 4735 Alhambra Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ (or) WIFE of Harry Norton

6 DATE OF BIRTH (month, day, and year) June 8th 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Hooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Mary's Co. Md

12 MAIDEN NAME OF MOTHER Henrietta Rumney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry Norton

(Address) 4735 Alhambra Ave

Filed JUL 22 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/21 1930

17 I HEREBY CERTIFY, That I attended deceased from 7/18/30, 19..., to 7/21/30, 19..., that I last saw h[er] alive on 7/21/30, 19..., and that death occurred, on the date stated above, at 7:45 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis over

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/18/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Uhlman, M. D.

, 19 (Address) West Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 7/25 1930

UNDERTAKER Wm Cook

ADDRESS 1217 N Paca St

How is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59007

CERTIFICATE OF DEATH

100-001

E 59007

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2631 Ashland Ave. ST., 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mildred A. Stupska.

(a) RESIDENCE NO. 2631 Ashland Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Child.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER John Stupska.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Vlasta Hijek.

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland.

14 Informant John Stupska
(Address) 2631 Ashland ave.

15 [illegible] 22 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1930

17 I HEREBY CERTIFY That I attended deceased from July 20, 1930, to July 22, 1930, that I last saw h[illegible] alive on July 22, 1930 and that death occurred, on the date stated above, at 8.00 A.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Joseph Pokorny, M. D.

19 (Address) 220 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cemetery	July 24 1930

20 UNDERTAKER August Tax[illegible] 2406 ADDRESS Ashland ave

Spec.—1-30—M. & T.—250 Blks

(Bertha N. Porter) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59008 × 46 E 59008

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 2-49 WARD

2-FULL NAME Mrs W. Roscoe Porter

(a) RESIDENCE NO. Forest Hills, Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 37 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. W R. Porter

6 DATE OF BIRTH (month, day, and year) 6-10-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER John Vaughan

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Byrd

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Roscoe Porter
(Address) Forest Hills Md

15 Filed ..... 19 ..... By ..... Registrar

C. HARRISON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to July 22, 1930, that I last saw her alive on July 22, 1930, and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) 3 yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Pelvic Abscess

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Forest Hills, Md

Did an operation precede death? Yes Date of 6-25-30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Post Mortem

(Signed) Richard I. Shackelford M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interment Gilboa Stanford Md

DATE OF BURIAL July 25 1930

UNDERTAKER Dean & Foster

ADDRESS Baltimore Md.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59009

CERTIFICATE OF DEATH

194 ✓

E 59009

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 834 Hanover St. St. 27-21 Ward)

2-FULL NAME Blandine A. Sauter.

(a) RESIDENCE NO. 834 Hanover St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. ---mos.---ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	69	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany.
(State or country)

PARENTS

10 NAME OF FATHER Carl Sauter.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Victoria Hohner.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Bernard Harle.
(Address) 115 E. West St.

15 Filed JUL 22 1930 C. HAMPSON JONES M. D. Registrar
By ---

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Prostration.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Leonhardt, M. D.

7/22 1930 (Address) 1017 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	7-23-1930
20 UNDERTAKER	ADDRESS
E & B Harle 115 E	West St.

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59010 E 59010

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 26-37 ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Fello

(a) RESIDENCE NO. none ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Justine

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Fello

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Ravolla

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Records of (Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar C. HAMPSON JONES, M. D.

7-22 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-21-30

17 I HEREBY CERTIFY, That I attended deceased from 6-8-29, 19..., to 7-21-30, 19..., that I last saw him alive on 7-21-30, 19..., and that death occurred, on the date stated above, at 8:50 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhages into cerebrum (multiple)

(duration) 3 yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Hypertension. Unknown.

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Paul Podgel, M. D.

7-22, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL 7/23 1930

20 UNDERTAKER Vernon Lemmon.

ADDRESS 4611 Park Heights Ave.

Spec.—1-10-21—M&T—1500 Bks.

E 59011 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59011

CERTIFICATE OF DEATH. 51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1012 W Cross St. 21-29 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Matthews Shilow

(a) RESIDENCE NO. 1012 W Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17, 1917

7 AGE: Years 13 Months 1 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School child

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Wilmer Shilow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Carrie Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Wilmer Shilow (Address) 1012 W Cross St

C. HAMPSON JONES, M. D. Registrar

JUL 22 1930

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1930

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1930, to July 21, 1930, that I last saw him alive on July 21, 1930 and that death occurred, on the date stated above, at 7:18 P. m. (D. S. T.).

The CAUSE OF DEATH* was as follows:

Acute rheumatic fever, bronchopneumonia, pericarditis, endocarditis, septicemia staphylococcic

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Cerebr. oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. data

(Signed) Leo Schlenger, M. D.

, 19 (Address) 3034 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 7/24 1930

20 UNDERTAKER H. M. Cook

ADDRESS 1214 E Pratt St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 59012 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59012

CERTIFICATE OF DEATH. 16-30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD) 30

2-FULL NAME Norma Parks

(a) RESIDENCE NO. Grasonville Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2 1926

7 AGE Years 4 Months 1 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Ephraim Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Irene Legg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Ephraim Parks

(Address) Grasonville Md

JUL 22 1930

C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 21, 1930, that I last saw her alive on July 21, 1930, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Dysentery - Bacillary

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Grasonville Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs & Symptoms

(Signed) Henry S. Merrick, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grasonville Md.

DATE OF BURIAL July 23 1930

20 UNDERTAKER Chenowith Son

ADDRESS 3615 Eastern Ave

See instructions on back of certificates. IT IS very important.

Spec.—1-10-21—M&T—1500 Bks.

E 59013

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59013

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3501 Belvedere ST. 27-56 WARD)

2-FULL NAME William F. Boyd

(a) RESIDENCE NO. 3507 Belvedere ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or ~~divorced~~
HUSBAND of
(or) ~~WIFE~~ of Nellie Boyd

6 DATE OF BIRTH (month, day, and year) 2. 11. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	05	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 104

(b) General nature of industry, business, or establishment in which employed (or employer) Book keeping

(c) Name of employer Penna R.R

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Samuel Boyd

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary C. Wagster

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mary C. Boyd
(Address) 1155 Schroeder St

15 Filed 7 2 1930 C. HAMPSON JONES, M. D. Registrar
Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7. 22. 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15 , 1930 , to July 21 , 1930,
that I last saw h alive on July 21 , 1930,
and that death occurred, on the date stated above, at 2. a m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis, Ventral
Regurgitation Chronic Cornea

(duration) 2 yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) E. H. Beeton, M. D.

7. 22. 1930 (Address) 1st Washington Ind

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL 7/25 1930

20 UNDERTAKER J. Frew McCully

ADDRESS 130 E Fayette

THIS IS very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 (Mrs. Joshua Springer) ✓ By Dr. Fuller ✓

E 59014 HEALTH DEPARTMENT—CITY OF BALTIMORE 194 E. 59014

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. (University Hospital 24-34 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johna Springer

(a) RESIDENCE NO. 1628 Balt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emeline Springer

6 DATE OF BIRTH (month, day, and year) Apr 2 - 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R.R. Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer) B & O. 073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware.

PARENTS

10 NAME OF FATHER George Springer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mrs. Springer (Address) 1628 Balt.

15 FILED JUL 22 1930 19 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1930, to July 20, 1930, that I last saw h[illegible] alive on July 20, 1930, and that death occurred, on the date stated above, at 8 a P. m.

The CAUSE OF DEATH* was as follows:

Heat Prostration

(duration) yrs. mos 1 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) George H. Yeager M. D.

7/21, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 7/22 1930

20 UNDERTAKER J. F. M.: Cully

ADDRESS 130 E Fort

Engineer of Locomotive 11 P. Crew Wreck

Spec.—8-16-29—L. F. S.—100 Blks.

E 59015 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59015

CERTIFICATE OF DEATH

75-002

REGISTERED NO. 23-33

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 E. West St. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Hartman

(a) RESIDENCE NO. 22 E. West St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 4 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Hartman

6 DATE OF BIRTH (month, day, and year) Mar. 13 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	4	8 7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Fay

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Michels

13 BIRTHPLACE OF MOTHER (city or town) Ger.
(State or country)

14 Informant Mr. Davis
(Address) 22 E. West St

15 Filed C. HAMPSON JONES, M. D. Registrar
JUL 22 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 10/29, 19..., to July 20/30, 19..., that I last saw h... alive on July 20/30, 19..., and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:

Pandysis
Cerebral

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Hyp Bloodpressure Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Jno. D. Kolb, M. D.

July 20/30 (Address) 130 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 7/23 1930

20 UNDERTAKER J. F. McCauley

ADDRESS 130 E Fayette

Spec.—1-30—M. & T.—250 Blks.

E 59016

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59016

CERTIFICATE OF DEATH.

X 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. 1st ST., 4-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph W. Norris

(a) RESIDENCE NO. Fullerton Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 23-1855

7 AGE	Years	Months	Days 29	If LESS than 1 day, hrs. or min.
	75	5		

8 OCCUPATION OF DECEASED Retired Seaman

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Charles Town W Va

(State or country)

10 NAME OF FATHER William H Norris

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Amey Lee

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

Ursula Bryan Norris.

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31. 1930

17 I HEREBY CERTIFY, That I attended deceased from July, 19.., to July 31, 1930.

that I last saw him alive on July 31, 1930.

and that death occurred, on the date stated above, at 10:50 A m.

The CAUSE OF DEATH* was as follows:

Ulcer of Duodenum

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Ludwigs angina

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of 7-14 30

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) George Deagen, M. D.

7-31. 1930 (Address) Univ. Hosp. Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Park Wood

DATE OF BURIAL July 33 30

20 UNDERTAKER M E Gosney

ADDRESS 84 W 67 St

C. HAMPSON JONES, M. D. Registrar

15 FILED 19 2 1930 BY

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59017

CERTIFICATE OF DEATH

36-002 ✓ E 59017

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 403 E. Lafayette St., 4-7 Ward)

2-FULL NAME Belle Stein

(a) RESIDENCE NO. 4039 Lafayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	86	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Rachel Stein
(Address) 403 Lafayette Ave

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar
Apr 27 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21-30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis
Coronary Disease Hypertension
(duration) yrs. mos. ds.
Acute Cystitis
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. J. Ruby, M. D.

July 22, 1930 (Address) 1639 Bremerton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL July 23 1930

20 UNDERTAKER Mary M Wadefield

ADDRESS 501 E 22

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 59018

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59018

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St Joseph's Hospital 9-18 (Ward)

2-FULL NAME Elizabeth Sidley

(a) RESIDENCE NO. 829 Aiken St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single~~, ~~Married~~, Widowed or ~~Divorced~~, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joseph Sidley

6 DATE OF BIRTH (month, day, and year) Nov 9 - 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	70	8	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England.

14 Informant Mrs. Neal P. Graves
(Address) 831 Aiken St.

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Manic Convulsions

(duration) 2 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary) Tongue & Pulmonary

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 829 Aiken

Did an operation precede death? Date of

Was there an autopsy? History

What test confirmed diagnosis? Clinical & Exam

(Signed) G. C. Eagles, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Londan Pk. Cem.

DATE OF BURIAL July 25 1930

20 UNDERTAKER Geo. W. Settle

ADDRESS 2700 Edmondson Ave

Important. See instructions on back of certificate.

JUL 22 1930

Spec.—1-30—M. & T.—250 Bks.

E 59019

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59019

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland University Hospital ST. 14-27 WARD

CITY OF BALTIMORE: (NO. .....

2-FULL NAME Martha B. Simmons

(a) RESIDENCE NO. 1505 W. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Geo H Simmons

6 DATE OF BIRTH (month, day, and year) May 1851

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	79	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Bridgetown (State or country) N.S.

PARENTS

10 NAME OF FATHER David Schultz

11 BIRTHPLACE OF FATHER (city or town) Bridgetown N.S. (State or country)

12 MAIDEN NAME OF MOTHER Louisa Mulford

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs. N. S. Christopher (Address) 2412 Walbrook Ave.

15 FILED 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22-30.

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to 8:50 P.M. July 21, 1930, that I last saw her alive on July 21, 1930, and that death occurred, on the date stated above, at 8:50 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency, congestive
Mitral stenosis

Chronic (duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Heat prostration
4 hrs. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? The autopsy

(Signed) ..... M. D.

(Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL JUL 23 1930

20 UNDERTAKER Geo H Little ADDRESS 2700 EDMONDSON AVE.

Spec.—1-30—M. & T.—250 Blks

E 59020 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59020

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 6-9 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Mary Linthicum

(a) RESIDENCE NO. 144 Jackson Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred: life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1850

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Chas. Lambdin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records of (Address): Balto. City Hosp.

15 Filed JUL 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-22-30

17 I HEREBY CERTIFY, That I attended deceased from 3-5-28, 19..., to 7-22-30, 19...,

that I last saw her alive on 7-22-30, 19...,

and that death occurred, on the date stated above, at 4:30 Am.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis chronic

(duration) yrs. mos. 8 days

18 Where was disease contracted if not at place of death? 1. Home. 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signed exam.

(Signed) Paul Padget, M. D.

7-22-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Comp.

DATE OF BURIAL JUL 24 1930

20 UNDERTAKER: Geo. W. Little

ADDRESS 2700 EDMONDSON AVE.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59021

E 59021

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Stevens Memorial Hosp St., 2748 Ward

2-FULL NAME Robert F. Robertson

(a) RESIDENCE NO. 5213 Craig Rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/10/1886

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	44	0	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Freight agent
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Wm Robertson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary S. Dalrymple

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs. G. Robertson
(Address) 521 Craig Rd

15 [illegible] C. HAMPSON JONES, M. D. Registrar

2 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tobacular Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

7/26/1930 (Address) 263 Poplar Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL London Park Cemetery

DATE OF BURIAL 7/24/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59022

CERTIFICATE OF DEATH

199

E 59022

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 1-2 Ward)

2-FULL NAME Francis J. Puth

(a) RESIDENCE NO. 252 - S. Bouldin St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliz. [Klinger]

6 DATE OF BIRTH (month, day, and year) 11-11-1859

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
70	8	10 9	X

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stonekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Jacob Puth

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Philips

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs. Wiley
(Address) 252 - Bouldin St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Homicide
Fracture of Skull, Blunt Instrument?

(duration) yrs. mos. 3 hrs.

CONTRIBUTORY (Secondary) Stroke

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

What test confirmed diagnosis? Autopsy

(Signed) M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 7/23/30

20 UNDERTAKER George J. Puth Inc

ADDRESS 1735 Hoffman

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59023

E 59023

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 6012 Glenmore Ave St., Ward 27-43 Old Hafad ave)

2-FULL NAME Elizabeth Campeggi

(a) RESIDENCE NO. 6012 Glenmore Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Campeggi

6 DATE OF BIRTH (month, day, and year) 12-30-1869

7 AGE	Years	Months	Days	IF LESS than 1 day, hrs. or min.
	60	6	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Johnson

11 BIRTHPLACE OF FATHER (city or town) N. H.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Gramling

13 BIRTHPLACE OF MOTHER (city or town) N. H.
(State or country)

14 Informant Eliz Campeggi
(Address) 6012 Glenmore

C. HAMPSON JONES, M. D. Registrar

2 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocard Stenosis

CONTRIBUTORY (Secondary) C & Lawson (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy

(Signed) H. C. Hades, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL 7/24/30

20 UNDERTAKER George J. Duff & Sons

ADDRESS 1735 Harford

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Mueller)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59024 E 59024

88

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 118 Landsdowne WARD 30-69

2-FULL NAME Anna K. Mueller

(a) RESIDENCE NO. 118 Landsdowne WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm G. Mueller

6 DATE OF BIRTH (month, day, and year) June 21-1853

7 AGE Years 77 Months — Days 29 30 If LESS than 1 day, ..hrs. or ..min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Ebert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant George G. Mueller

(Address) 118 Landsdowne

15 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 1930

17 I HEREBY CERTIFY, That I attended deceased from 7/15/30, 1930, to July 19, 1930, that I last saw her alive on July 17, 1930, and that death occurred, on the date stated above, at 8 45 a.m.

The CAUSE OF DEATH* was as follows:

Hypostasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. O. Fowler, M. D.

, 19 (Address) 9 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery | DATE OF BURIAL July 23 1930

20 UNDERTAKER George L. Schwartz | ADDRESS 1000 Eutaw St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59025 E 59025

CERTIFICATE OF DEATH.

118-8

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 70-28 WARD)

2-FULL NAME Elsie Romm

(a) RESIDENCE NO. 1935 Christian ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 23-1930

7 AGE	Months	Days	If LESS than 1 day, hrs or min.
3 months		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER Hunter Romm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Margaret Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Mrs Margaret Romm 1935 Christian St

15 Filed 7-23 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-20 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-19 1930 to 7-20 1930

that I last saw her alive on 7-20 1930,

and that death occurred, on the date stated above, at 8 25 P. m.

The CAUSE OF DEATH* was as follows: —

Intussusception - small bowel

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? Yes —

What test confirmed diagnosis? Specimen

(Signed) Hjalmar S. Anderson, M. D.

19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL July 23 1930

20 UNDERTAKER George L. Eshman — ADDRESS 2101 Eutaw Pl.

Spec.—1-10-21—M&T—1500 Blks.

E 59026 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59026

47

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Avenue St.) 40-69 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Koss

(a) RESIDENCE NO. 302 S Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18 - 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	61	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Koss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelie Hense

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Koss

(Address) 302 S Payson St.

2 1930 .19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-20 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-7 .1930 . to 7-20 .1930 .

that I last saw her alive on 7-20 .1930 ,

and that death occurred, on the date stated above, at 4.40 P m.

The CAUSE OF DEATH* was as follows: (a) Standard line

Carcinoma of Breast

generalized Metastases

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hjalmar S Anderson M. D.

.19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL July 23 1930

20 UNDERTAKER George L. Schwatt ADDRESS 2101 Eutaw Ave.

Spec.—1-30—M. & T.—250 Bks.

E 59027 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59027

CERTIFICATE OF DEATH.

194

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 S. Bond ST 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia DeMartin

(a) RESIDENCE NO. 520 S. Bond St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 07

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Gorski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Weber Daughter

(Address) 522 S. Bond St.

Filed 7-2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to July 22, 1930, that I last saw h— alive on July 19— 1930, and that death occurred, on the date stated above, at 6:50 a. m.

The CAUSE OF DEATH* was as follows:

Cortico-Vascular Dis —

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Hemi-Hydrothorax

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

, 19 (Address) 125 W. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. July

DATE OF BURIAL: 24 1930

20 UNDERTAKER: John M. Weber & Son

ADDRESS: Chester

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 59028

59028

CERTIFICATE OF DEATH. × 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 6-9 WARD)

2-FULL NAME Waters Ford

(a) RESIDENCE NO. Rutwell, P.O. Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary Ford

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oysterman

(b) General nature of industry, business, or establishment in which employed (or employer) Oyster

(c) Name of employer

9 BIRTHPLACE (city or town) ? (State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Robert Woods Friendship md (Address)

15 3 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to July 22, 1930, that I last saw him alive on July 22, 1930, and that death occurred, on the date stated above, at 6:40 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

Chronic myocarditis

Insidiously (duration) yrs. mos da.

CONTRIBUTORY (Secondary) Bronchopneumonia

3 (duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M E Glenn M. D.

7/22 1930 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lamer a & Co. DATE OF BURIAL July 23 1930

20 UNDERTAKER B L Hopping ADDRESS Annapolis Md

Spec.—1-30—M. & T.—250 Blks

E 59029 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 59029

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 12-49

CITY OF BALTIMORE: (No. ..... ST. 12-49 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Charles L. Goldsborough

(a) RESIDENCE NO. 25 E Cor New York ST., —— WARD New York City, N.Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Mrs. C. L. Goldsborough.

6 DATE OF BIRTH (month, day, and year) Nov. 28, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 20 min.
66	66	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer, retired 08

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Talbot County, Maryland

PARENTS

10 NAME OF FATHER Nicholas Goldsborough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Virna Turner Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Wife (Address) 20 Fifth Ave, New York City, N.Y.

15 FILED JUL 23 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1930, to July 23, 1930, that I last saw him alive on July 23, 1930, and that death occurred, on the date stated above, at 1.30 A.m. (Daylight Saving)

The CAUSE OF DEATH* was as follows:

General Carcinomatosis, primary site unknown

(duration) — yrs. 7 mos 7 ds.

CONTRIBUTORY (Secondary) —— (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? New York City, N.Y.

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical course.

(Signed) Frances P. Block, M. D.

7/23 1930 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oxford Md — DATE OF BURIAL July 23, 1930

20 UNDERTAKER Henry Hopkins Sons — ADDRESS Oxford Md

Spec.—1-30—M. & T.—250 Bks.

238989

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 59030

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 27-49 WARD)

2-FULL NAME Dr. Wyatt Randall

(a) RESIDENCE No. 430 S Rugby Rd ST., ... WARD Guilford
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) ~~WIFE of~~ Elizabeth Colston

6 DATE OF BIRTH (month, day, and year) Jan 10 1867

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer) Md

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Alex Randall

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Eliz. Blanchard

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Bonds
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 23 1930, 19 .....

HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22-30

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to July 22, 1930, that I last saw him alive on July 22, 1930, and that death occurred, on the date stated above, at 8 05 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of July 19, 1930.

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) [signature], M. D.

7/22 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	July 24, 19
20 UNDERTAKER Henry A. Jenkins Sons Co	ADDRESS 22 Light St

Spec.—1-30—M. & T.—250 Bks.

2 3 8946 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 3 2 E 59031
E 59031

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL ST. 11-24 WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Pearl Green Beal

(a) RESIDENCE NO. 1222 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black.	unknown

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Charles Green

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER Lessie Green

13 BIRTHPLACE OF MOTHER (city or town) N Car
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 23 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-21-1930

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 21, 1930, that I last saw her alive on July 21, 1930, and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis
Disseminated tuberculosis

(duration) yrs. mos 12 ds. +

CONTRIBUTORY (Secondary) Disseminated TBC

(duration) ? 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal Puncture

(Signed) Hedwig Kroeger M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery DATE OF BURIAL July 24 1930

20 UNDERTAKER Clive H. Johnson ADDRESS 486 N. Carolina St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59032 49 E 59032

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Maryland General Hosp. Linden ave and Madison ST. 11E 24 WARD)

2—FULL NAME Charles Lee

(a) RESIDENCE NO. 725 Linden ST., WARD Baltimore, Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Charles Lee

DATE OF BIRTH (month, day, and year) Dec. 26, 1882

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47	48	6	7 24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Arnold Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Margaret Baron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

Informant Hospital record.

(Address)

J. HARRISON JONES, M. D.

Registrar

2 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1930

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1930, to July 20, 1930, that I last saw him alive on July 19, 1930, and that death occurred, on the date stated above, at 2:40 a.m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma of Abdomen

(duration) yrs. 7-8 ? mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of July 11, 1930

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Robert W. Lemmitt M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 23 1930
20 UNDERTAKER John H. Joadson	ADDRESS 1027 Hanover

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

L 59033 90 E 59033

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 626 W. Fayette St., 4-25 Ward)

2-FULL NAME Amelia Cohen

(a) RESIDENCE NO. 626 W. Fayette St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-work
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Tenn.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Jack Lewis
(Address) 1434 E. Balto. St.

15 FILED JUL 23 1930 WILLIAM H. JAMES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Kelly, M. D.

7/22 1930 (Address) 2736 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bals. Hebrew Cem. DATE OF BURIAL July 23 1930

20 UNDERTAKER Jack Lewis ADDRESS 1434 E Balto St

Per .....

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59034

CERTIFICATE OF DEATH.

E 59034

1-PLACE OF DEATH Hebrew Home for Aged & Infirm REGISTERED NO.

CITY OF BALTIMORE: (No. 21-54 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Jacob Goldman

(a) RESIDENCE NO. Leindale Greenspring Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Goldman

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE: Years 81 Months — Days . If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Superintendent Leindale

15 Filed 7 1930, 19 Per C. HAMERON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-10, 1930, to 7-22, 1930, that I last saw him alive on 7-22, 1930 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edmund Levin, M. D.

, 19 (Address) Leindale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosh Rod DATE OF BURIAL: July 23 1930

UNDERTAKER: Lewis ADDRESS: 1429 E Balto

Spec.—8-16-29—L. F. S.—100 Bks.

E 59035

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

E 59035

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Ann St 411 ST., 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Monroe

(a) RESIDENCE NO. Ann N. St 411 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Payton Monroe

6 DATE OF BIRTH (month, day, and year) 18.77

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED House Wife

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Henry Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary ann Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Peyton Monroe

(Address) 411 N. ann st

15 Filed 2 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/21/30.

17 I HEREBY CERTIFY, That I attended deceased from Jan 25 1930, to July 21 1930, that I last saw h alive on July 21 1930 and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

2

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease (duration) yrs. 6. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C H Reyburn M. D.

7/22/1930 (Address) 1520 E. 33rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery — DATE OF BURIAL: July 24 1930

20 UNDERTAKER: Edward Bryan — ADDRESS: 1601 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59036

E 59036

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH Howard Kelly Hospital

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST. 15-6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Jeanette Irving Lower

(a) RESIDENCE NO. 2200 Garrison Blvd. WARD Baltimore Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22nd 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	45	6 mos.		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Jarrattown
(State or country) Pa.

PARENTS

10 NAME OF FATHER Wm C. Lower

11 BIRTHPLACE OF FATHER (city or town) Jarrattown
(State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Marple

13 BIRTHPLACE OF MOTHER (city or town) Hatboro
(State or country) Pa

14 Informant Mrs N. M. Lower
(Address) 2200 Garrison Blvd. Balto

15 Filed JUL 23 1930 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I attended deceased from April 8th, 19 27 to July 22, 19 30
that I last saw h alive on July 22, 19 30
and that death occurred, on the date stated above, at 5-00 P m.

The CAUSE OF DEATH* was as follows:

Adeno carcinoma.
Rt breast. c
Generalized metastases

(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 30 1929

Was there an autopsy? Yes Pathological Examination

What test confirmed diagnosis?

(Signed) William Cecil Jr M. D.

July 22, 1930 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bon Air cemetery Ambler Penna DATE OF BURIAL 7/25 1930

20 UNDERTAKER Chas. S. Black ADDRESS 742 W North Ave

Spec.—1-12-23—M&T—500 Blks.

William H. Rosenberger

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 59037 — 129 ✓ — E 59037

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 Eutaw ST., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME W. H. Rosenberger

(a) RESIDENCE No. 1323 Eutaw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Celia Rosenberger

6 DATE OF BIRTH (month, day, and year): Dec 1852

7 AGE — Years: 78 — Months: 5 — Days: — If less than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant: W. Rosenberger (Address) Same

15 Filed JUL 31 1930 C. H. Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 21, 1930, that I last saw h[illegible] alive on July 21, 1930 and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Valvular Heart Disease

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

July 23, 1930 Address 1823 N. Haven St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — July 24-30

DATE OF BURIAL

20 UNDERTAKER: Jos. J. Henderson

ADDRESS 3007 Kenilworth Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 59038

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59038

CERTIFICATE OF DEATH.

Registered No. 194

1-PLACE OF DEATH

City of BALTIMORE: (No.) 514 N Pine St. 17-26 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Savage

(a) Residence No. 514 N Pine St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of 0

6-DATE OF BIRTH (month, day and year) Feb 6 1930

7-AGE. 5 mos. 15 ds. If LESS than 1 day, hrs. or min.? 16

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, Vernon Savage

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Lottie Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Md

14- (informant) Lottie Savage

(Address) 514 N Pine St

15- Filed JUL 23 1930 C. HAMILTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 22, 30

17- I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 22, 1930, that I last saw h[illegible] alive on July 22, 1930, and that death occurred, on the date stated above, at 11:47 m.

THE CAUSE OF DEATH was as follows: Bronchial Pneumonia

(Duration) 2 ds.

CONTRIBUTORY (Secondary) Heart

(Duration) yrs. mos. da

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John C Stewart, M. D.

19 (Address) 704 W Lafayette Ave

July 22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, NW Cemetery DATE OF BURIAL, July 23, 1930

20-UNDERTAKER, S L & Brown's Son ADDRESS 108 W Monument St

Spec.—1-30—M. & T.—250 Bks.

59039

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 V E 59039

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland University Hospital

CITY OF BALTIMORE: (NO. ..... ST. 23-31 WARD

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Washington Jackson

(a) RESIDENCE NO. 129 N. West ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

6a If married, widowed, or divorced HUSBAND of or) WIFE of Leo Jackson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 27

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Olsten Washington

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Annie Washington

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Edna Lee

(Address) 129 N. West St

15 Filed ..... 1930 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 21, 1930, that I last saw her alive on July 21, 1930, and that death occurred, on the date stated above, at 3:42 P. m.

The CAUSE OF DEATH[a] was as follows:

Syphilis, tertiary

Unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Aneurism of heart, Hypertrophy of heart, insufficiency and Stenosis, Pulmonary, Pneumonia, Gangrene of Lung

Pneumonia (duration) 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical, Microscopic, Wassermann, Physical.

(Signed) J. S. Lynch, M. D.

, 19 (Address) Univ. Hospital.

[a]State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL July 29 1930

20 UNDERTAKER J. H. Brown's Son

ADDRESS 108 W. Mulberry St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59040

CERTIFICATE OF DEATH.

113 E 59040

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1719 (ST.) Riverside Ave (WARD) 23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Hall

(a) RESIDENCE NO. 1719 (ST.) Riverside WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16 1929

7 AGE: Years | Months | Days: 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Kinsey Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hampden Md

12 MAIDEN NAME OF MOTHER: Margaret Pepersack

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hampden Md

14 Informant (Address): Margaret Hall 1719 Riverside Ave

15 Filed 2-3-1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24/30 19

17 I HEREBY CERTIFY, That I attended deceased from July 20/30, 19 to July 24/30, 19; that I last saw him alive on July 20/30, 19; and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) 2 days yrs. mos da.

CONTRIBUTORY (Secondary) Pneumonia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Harry B Hall M. D.

July 29 1930 (Address) 1923 Eyler

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer DATE OF BURIAL July 23 1930

20 UNDERTAKER: Margaret S. Flynn ADDRESS 1422 Light St

Spec.—1-12-23—M&T—500 Blks.

Jones

HEALTH DEPARTMENT—CITY OF BALTIMORE

59041 — CERTIFICATE OF DEATH. — 57 — E 59041

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1041 Brantley ave (WARD) 46-16

2-FULL NAME Joseph H. Jones

(a) RESIDENCE NO. 1041 Brantley ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~ Widowed, or ~~Divorced~~, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 2. 1867

7 AGE: Years 62 | Months 8 | Days 20 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sign maker

(b) General nature of industry, business, or establishment in which employed (or employer): B X O R R. 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Henry D. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rosanna McNulty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Y.

14 Informant: Catherine Jones

(Address): 1041 Brantley ave

Filed 23 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1930, to July 22nd, 1930, that I last saw h[illegible] alive on July 21st, 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Diabetes Gangrene

(duration) ..... yrs. 3 mos 7 ds.

CONTRIBUTORY (Secondary) Left Hemoplegia

(duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Joseph D. Nuckols M. D.

19 (Address) 2419 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Peters County — DATE OF BURIAL: July 24 1930

20 UNDERTAKER: J. A. Kraemer Sr — ADDRESS: 703 Hamm

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59042 E 59042

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 637 George ST. 17-25 (WARD)

2-FULL NAME Judith Fitzgerald

(a) RESIDENCE NO. 637 George ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Fitzgerald

6 DATE OF BIRTH (month, day, and year): 5/12 - 1883

7 AGE: Years 47 | Months 5-2 | Days 13-18 | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va Baltimore

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): James Fitzgerald 637 George

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/21 1930

17 I HEREBY CERTIFY, That I attended deceased from 6/1, 1930, to 7/21, 1930, that I last saw h[illegible] alive on 7/21, 1930, and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage Paralysis

(duration) ..... yrs. 1 mos 20 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Benj Rhett M. D.

July 22, 1930 (Address) 2129 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

20 UNDERTAKER: Kent Eosler

DATE OF BURIAL: 7-23-30

ADDRESS 916 Ea 42

FILED JUL 23 1930

Cor.—12-9-25—A Co.—200 Bks.

E 59043

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 E 59043

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1141 N. Gilmor St. 16-22 Ward)

2-FULL NAME Jack Johnson

(a) RESIDENCE NO. 1141 N. Gilmor St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): Aug 31 1921

7 AGE: Years 18 Months Days 22 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Jack Johnson

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Margaret Bros

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Margaret Johnson

(Address) 1141 N. Gilmor

Filed JUL 23 1930 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

(Coroner)

July 22 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial 7-23 1930

20 UNDERTAKER: Frank Carlin ADDRESS 916 Lafayette

Spec.—1-30—M. & T.—250 Bks.

E 59044

E 59044

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 194

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 653 N. Paca ST. 17-25 WARD)

2-FULL NAME Jennie B. Atches

(a) RESIDENCE NO. 653 N. Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 24-1855

7 AGE: Years 74 | Months 6 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fredericksburg Va

10 NAME OF FATHER Henry Byrd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Gertrude Mosley

(Address) 653 N Paca St

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-20/30

17 I HEREBY CERTIFY, That I attended deceased from July 16. 1930, to July 20. 1930 that I last saw her alive on July 19. 1930 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Chronic Heart & Valvular Heart disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy

(Signed) H K Jones M. D.

19 (Address) 1 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lawn | DATE OF BURIAL July 23 30

UNDERTAKER Emma Kinsley | ADDRESS 1708 Bridle

Spec.—1-30—M. & T.—250 Bks.

E 59045

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59045

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Mt Hope Retreat St. 28-63

2-FULL NAME Ellen Dailey (Ellen Dailey)

(a) RESIDENCE NO. Mt Hope Retreat ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of John Thomas Dailey

DATE OF BIRTH (month, day, and year) May 12, 1833

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
97	~~93~~	2 ~~10~~	~~25~~ 19	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

BIRTHPLACE (city or town) Westminster
(State or country) Maryland Md.

10 NAME OF FATHER Richard Warfield
11 BIRTHPLACE OF FATHER (city or town) Westminster
(State or country) Md
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown

Informant Mt Hope Retreat
(Address) Mt Hope Retreat

Filed 19 Register No.

C. HAMPSON JONES, M. D.

31930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to July 21, 1930,
that I last saw h[illegible] alive on July 21, 1930,
and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral haemorrhage.
(Hemiplegia)

(duration) — yrs. — mos. 2 ds.
CONTRIBUTORY (Secondary) Senile dementia
(duration) 30 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) Milton P. Dell, M. D.
5/21, 1930 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Family Church Cemetery, Harrisonville, Md.
DATE OF BURIAL July 24, 30

UNDERTAKER [illegible]
ADDRESS 1003 West Baltimore St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59046

CERTIFICATE OF DEATH

194 E 59046

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1511 McCulloh St., 14-20 Ward

2-FULL NAME Robt B Brown

(a) RESIDENCE No. 1511 McCulloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11 1884

7 AGE: Years 46 | Months 2 | Days 10 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work See below
(b) General nature of industry, business, or establishment in which employed (or employer) 045
(c) Name of employer

9 BIRTHPLACE (city or town) Chas Co Va
(State or country)

PARENTS

10 NAME OF FATHER Walter J Brown

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Susan Black

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Walter Brown
(Address) 2113 Laurens

Filed JUL 23 1930 C. HAMPSON JONES, Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Prostration
(duration) ..... yrs. four hrs. ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) ..... M. D.

July 21 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chas. City Co. Va.	July 25 1930
20 UNDERTAKER	ADDRESS
Geo. H. Holland	631 D St

Spec.—1-30—M. & T.—250 Bks

E 59047 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 59047

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (NO. ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carlyle Yerby

(a) RESIDENCE NO. 1508 Madison ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 31, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Sharps

(State or country) Virginia

10 NAME OF FATHER Robert Yerby

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Alice Ward

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address) C. HAMPSON JONES, M.D.

15 Filed 7-23 1930, 19 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to July 21, 1930, that I last saw him alive on July 21, 1930, and that death occurred, on the date stated above, at 3.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Jenser, M. D.

7-21 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Co. Sharps DATE OF BURIAL July 24-1930

UNDERTAKER Geo. H. Kelland ADDRESS 31 Dock

Spec.—6-9-19—H. P. Co.—1000 Bks.

WITZ.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59048

CERTIFICATE OF DEATH.

194

E 59048

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1836 Rutland Ave (St.) 8-17 (Ward)

2-FULL NAME Elmina Witz

(a) RESIDENCE. No. 1836 Rutland Ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of wife Witz

6 DATE OF BIRTH (month, day, and year) Aug 2 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. md.

PARENTS

10 NAME OF FATHER Joseph Underwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md

12 MAIDEN NAME OF MOTHER Mary O'Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant (Address) John Lowschke 1836 Rutland ave

15 Filed JUL 23 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I attended deceased from April 6 1930 to July 22 1930, that I last saw h alive on July 22 1930, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows: Coronary heart

Myocardial Degeneration (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) H. C. Kerner M. D.

July 23 1930 (Address) 130 W Park pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 25, 1930
20 UNDERTAKER	ADDRESS
Curley & Co. Inc.	1021 W Lanvale

Spec.—1-30—M. & T.—250 Bks.

E 59049

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59049

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 30-27 ST. WARD)

2-FULL NAME Lucy Irvin

(a) RESIDENCE NO. Baltimore City Hospital ST. WARD 9a

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) July 5-1907

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	—	17	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student Nurse 046

(b) General nature of industry, business, or establishment in which employed (or employer) Hospital

(c) Name of employer Baltimore City

BIRTHPLACE (city or town) Clifton Forge

(State or country) Virginia

10 NAME OF FATHER Robert Irvin

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Josie Lush

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Virginia

14 Informant Hospital Records.

(Address) Baltimore City Hosp.

15 Filed 7-23 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22-30

17 I HEREBY CERTIFY, That I attended deceased from 5-27-, 1930, to 7-22-, 1930, that I last saw h[illegible] alive on 7-22-, 1930, and that death occurred, on the date stated above, at 8.00 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 6-21-30

Was there an autopsy? Yes Diagnosis

What test confirmed diagnosis? Operation.

(Signed) Fred M. Duckwall, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clifton Forge Va

20 UNDERTAKER Wm Cook

DATE OF BURIAL 7/23 1930

ADDRESS 1217 S. Gay

Spec.—1-30—M. & T.—250 Bks.

E 59050

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO. E 59050

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. South Baltimore General ST., 70-6 WARD

2-FULL NAME Christian Feick

(a) RESIDENCE NO. 232 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline A. Feick

6 DATE OF BIRTH (month, day, and year) April 3rd 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper 008

(b) General nature of industry, business, or establishment in which employed (or employer) J. Lang & Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Fred K. Feick

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Bolander

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

PARENTS

14 Informant Caroline A. Feick

(Address) 232 W. Fayette St.

15 Filed JUL 23 1930, 19 Per C. HAROLD SON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22-30

17 I HEREBY CERTIFY, That I attended deceased from 4-16, 1930, to 7-22, 1930, that I last saw him alive on 7-22, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic uremia

Acute Cardiac Failure

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis, Hypertrophied Prostate (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Joseph Laukaitis, M. D.

, 19 (Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 7/25/1930

UNDERTAKER

ADDRESS

E. H. Hunt - 850 W. Balto St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 59051
1-PLACE OF DEATH

109-002

E 59051
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) West Baltimore General Hospital (St.) (Ward)

2-FULL NAME Mrs. Katherine Bantheim

(a) RESIDENCE No. 515 Stamford Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Howard A Bantheim

6 DATE OF BIRTH (month, day, and year): Jan 28 1876

7 AGE: Years 54 | Months 5 | Days 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Bartholomew

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Reif

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Howard A Bantheim
(Address) 515 Stamford Rd

JUL 23 1930

C. HAMPSON JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1930

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 22, 1930.

That I last saw her alive on July 22, 1930.

And that death occurred, on the date stated above, at 4.50 p. m.

The CAUSE OF DEATH* was as follows:

Septicemia following septic sore throat

(duration) 1 yrs. — mos. 19 ds.

CONTRIBUTORY (Secondary): Hemorrhage from toxic enteritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry Ashman, M. D.

, 19 (Address) West Balto. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 7/25/30

UNDERTAKER: F. A. Stuppert

ADDRESS: 850 W. Balto St

Spec.—1-30—M. & T.—350 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59052

CERTIFICATE OF DEATH.

179

REGISTERED NO. E 59052

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1935 W. Lexington ST. 20-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne A. Old

(a) RESIDENCE NO. 1935 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 7 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of John Old

DATE OF BIRTH (month, day, and year) Dec 1st 1858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	7	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (City or town) Baltimore (State or country) Md

10 NAME OF FATHER Theodore Schafer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Robust

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Pennsylvania

Informant John A. Old

(Address) 1935 W. Lexington St.

Filed JUL 23 1930 C. HAMPSON JONES, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22/30

17 I HEREBY CERTIFY, That I attended deceased from April, 1930, to July 22, 1930, that I last saw h alive on July 22 1930, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

Chronic Nephritis

(duration) 3 yrs. mos da.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Kelly E. Cochran M. D.

7/23, 1930 (Address) W. Lexington 2002

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL 7/25/1930

20 UNDERTAKER H. S. Wappert ADDRESS 1850 W Balto St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59053

166 ✓ E 59053

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2215 Booth St. 9-46 Ward)

2-FULL NAME Elsie L. Bees

(a) RESIDENCE NO. 2215 Booth St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 6 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Martin L. Bees

6 DATE OF BIRTH (month, day, and year): Jan 5th 1904

7 AGE: Years 26 Months 6 Days 15 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

10 NAME OF FATHER: Ellen Eden

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Kaufman

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Md.

PARENTS

14 Informant: Martin L. Bees

(Address): 2215 Booth St.

15 Filed: C. HAMPSON JONES, M. D. Registrar

L 2-3 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: (10 m Stained)

Suicide by Bichloride Poison

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....(duration) ....yrs. ....mos. ....ds.

(Signed) Edward A. Brooks M. D. (Coroner)

July 24 1930 (Address) Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Park Cemetery Date of Burial 7/24/1930

UNDERTAKER: F. D. Wyckoff ADDRESS 1650 N. Baltimore

Spec.—1-30—M. & T.—250 Bks.

59054 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59054

1929 62 69

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 No. Paul St. 20-69 WARD)

2-FULL NAME Dora Felger

(a) RESIDENCE NO. 113 No. Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of: Louis F. Felger

DATE OF BIRTH (month, day, and year): Mch 10 1869

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	60	4	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER: Wm Litchtenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Barbara Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Louis F. Felger

(Address) 113 No. Paul St

C. HAMPSON JONES, M. D. Registrar

Filed 23 1930 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 20, 1930, that I last saw h alive on July 20, 1930; and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

July 22 1930 (Address) 208 E. Preston, Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: July 25 1930

UNDERTAKER: F. B. Hufford

ADDRESS: 1850 W. Baltimore

Spec.—1-30—M. & T.—250 Bks.

E 59055 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59055

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1008 W. 38 St (ST.) 13th (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Franklin Newton

(a) RESIDENCE NO. 1008 W. 38th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Newton (Mrs)

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
59			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cotton Mill Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton Mill

(c) Name of employer Md. Ex. Cotton Duck Co.

BIRTHPLACE (city or town) (State or country) Carroll Co Md

10 NAME OF FATHER J. C. Newton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Lillie Newton

(Address) 1008 W. 38th St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21-30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1928, to July 21, 1930,

that I last saw h[illegible] alive on July 21, 1930,

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yr. 2 mos 3 ds.

CONTRIBUTORY (Secondary) Chron. Int. Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? Clinical

(Signed) Wm J Kelly, M. D.

7/23/30 (Address) 608 Somerset Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 19

ADDRESS Lakeland

20 UNDERTAKER C. Hampson Jones, M. D. Pugh 3631

JUL 23 1930

C. HAMPSON JONES, Registrar

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59056

CERTIFICATE OF DEATH.

18 E 59056

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat ST. 26-63 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Frances Monahan

(a) RESIDENCE NO. Mt Hope Retreat ST. 28th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? 16 yrs 6 mos 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of X

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Abt	50	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Liverpool Eng.

10 NAME OF FATHER Michael Monahan

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Kelleher

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland

Informant Records (Address) Mt Hope Retreat

Filed OCT 23 1930 HAMPTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22nd 1930

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1914, to July 22nd, 1930, that I last saw her alive on July 21st, 1930, and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Ex Status Epilepticus

a few hours (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Epileptic Mania (duration) 26 yrs. 0 mos. 0 da.

18 Where was disease contracted if not at place of death? Hoboken N.J.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

July 22, 1930 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cem DATE OF BURIAL 7/24/30

UNDERTAKER Geo A Farley ADDRESS Fulton Laytonsville

Spec.—1-30—M. & T.—250 Bks

59057

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 59057

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 22-30 WARD)

CITY OF BALTIMORE: (NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Hornsby

(a) RESIDENCE NO. 16 Hanover Market ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

DATE OF BIRTH (month, day, and year) Jan. 11, 1858

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Northumberland Co.
(State or country) Va.

10 NAME OF FATHER James Hornsby

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Biddy Bridgette

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

Informant Records of
(Address) Balto. City Hospitals

Filed 7-23 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-21-30

17 I HEREBY CERTIFY, That I attended deceased from 7-15-30, 19..., to 7-21-30, 19...,

that I last saw him alive on 7-21-30, 19...,

and that death occurred, on the date stated above, at 11;45 Pm.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis UNKNOWN.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett, M. D.

7-22, 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Filbert Va

UNDERTAKER Wm Cook

DATE OF BURIAL 7/23 1930

ADDRESS 1175 Pine

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59058

CERTIFICATE OF DEATH.

49 E 59058

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO 911 S. Kenwood Ave WARD 1-1)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Piker

(a) RESIDENCE. NO. 911 S. Kenwood ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3rd 1920

7 AGE: Years 10 Months 2 Days 19

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: school boy

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank Piker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Marie Scaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Frank Piker 911 S. Kenwood ave

Filed 7-23 1930 H. [illegible] JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I attended deceased from May 23 1930 to July 15 1930 that I last saw him alive on July 22 1930 and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Osteogenic Sarcoma right femur (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary & Liver metastases duration yrs. mos. ds.

Cardiac Respiratory failure

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of Johns Hopkins Hosp.

Was there an autopsy? none

What test confirmed diagnosis? Pathological & Roentgenological

(Signed) Charles A. Waters M. D.

, 19 (Address) 1100 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Redemer Cem — DATE OF BURIAL: 7/26 1930

20 UNDERTAKER: H. Rosenstein — ADDRESS: 1177 Kenwood

Spec.—1-12-23—M&T—500 Bks.

Cervenka ✓

59059

HEALTH DEPARTMENT—CITY OF BALTIMORE

160 59059

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 561/4 Belair Rd ST., 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Mr & Mrs Walter V Cervenka.

(a) RESIDENCE NO. 561/4 Belair Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) July 18-1930

8 AGE: Years | Months | Days: 4 | If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto, Md. (State or country)

10 NAME OF FATHER Walter V. Cervenka.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Elizabeth Pruschoffer.

13 BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or country)

14 Informant Mrs Walter V. Cervenka. (Address) 561/4 Belair Rd

Filed 7-23 1930 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to July 22, 1930, that I last saw her alive on July 22, 1930, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) yrs. mos X ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinically

(Signed) W. H. Campbell M. D.

7/22, 1930 (Address) 16x4 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dorsey Cem

DATE OF BURIAL 7/23 1930

UNDERTAKER J. F. Cahill Sons

ADDRESS 1218 Light St

Spec.—1-30—M. & T.—250 Blks.

E 59060

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 59060

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Little Sisters of the Poor ST. (WARD)

2-FULL NAME Edward Wright

(a) RESIDENCE NO. 1200 Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) May 1864

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	2		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. gdl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Peru

10 NAME OF FATHER Andrew Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Uruguay

12 MAIDEN NAME OF MOTHER Cornelia Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Uruguay

Informant Good Mother Joseph

(Address) Little Sisters of the Poor

23 1930 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1930, to July 22, 1930, that I last saw h[illegible] alive on July 21, 1930, and that death occurred, on the date stated above, at 1:50 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Uremia

Unknown (duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) ....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Ross, M. D.

7-23-1930 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL July 24 1930

20 UNDERTAKER Rita Riedefeld — ADDRESS 914 Gremmt Ave

Spec.—1-30—M. & T.—250 Bks

E 59061 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59061

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 47-25 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ross

(a) RESIDENCE NO. 527 N. Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1861

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Records of

(Address) Balto. City Hosp.

Filed JUL 23 1930 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-20-30

17 I HEREBY CERTIFY, That I attended deceased from 6-13-25, 19..., to 7-20-30, 19..., that I last saw her alive on 7-20-30, 19..., and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute.

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Hemorrhage into cerebrum (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical exam.

(Signed) Paul Padget, M. D.

7-22, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER M. Commissioner Health

ADDRESS

JUL 23 1930

Spec.—1-30—M. & T.—250 Blks

E 59062 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59062

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 11-24 S. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Smith

(a) RESIDENCE NO. 1006 Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) April 6, ?

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47 ?	3	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

BIRTHPLACE (city or town) Danville

(State or country) Va.

10 NAME OF FATHER Barry Smith

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Lizzie ?

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

Informant Records of

(Address) Balto. City Hosp.

Filed 3-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-19-30

17 I HEREBY CERTIFY, That I attended deceased from 6-19-30, 19, to 7-19-30, 19,

that I last saw him alive on 7-19-30, 19,

and that death occurred, on the date stated above, at 1:40 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett, M. D.

7-22 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUL 23 1930

20 UNDERTAKER Commissioner Health

ADDRESS

Spec.—1-30—M. & T.—250 Bks

E 59063 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59063

38

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH: Baltimore City Hospitals ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.) Carrie Anderson

2-FULL NAME

(a) RESIDENCE NO. 1116 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar

DATE OF BIRTH (month, day, and year) Oct. 20, 1903

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
26	27	8	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): 021

(c) Name of employer

BIRTHPLACE (city or town) (State or country): N. C.

10 NAME OF FATHER: James Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Patsy Queary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

Informant: Records of

(Address): Baltimore City Hospitals

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-18-30

17 I HEREBY CERTIFY, That I attended deceased from 6-18-30, 19..., to 7-18-30, 19..., that I last saw him alive on 7-18-30, 19..., and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta with aortic insufficiency.

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, CHRONIC (duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical. Wasserman.

(Signed) Paul Podgett, M. D.

7-22 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: JUL 23 1930 19

ADDRESS

20 UNDERTAKER: Commissioner Health.

Per Wm. E. Woodall

FILED JUL 23 1930 C. HAMPSON JONES, M. D. Registrar

By

Spec.—1-30—M. & T.—250 Bks

E 59064

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59064

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1405 Fremont Ave ST. 14-20 (WARD)

2-FULL NAME Martha Ross

(a) RESIDENCE NO. 1405 Fremont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	B	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Richard Ross

DATE OF BIRTH (month, day, and year) 1878

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

Informant Gertrude Banks

(Address) Edmondson Md

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to July 21, 1930,

that I last saw her alive on July 19, 1930,

and that death occurred, on the date stated above, at 6.55a m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Probably (duration) 3 yrs. or less mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank Lehnen, M. D.

, 19 (Address) 2305 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 7-24-1930

20 UNDERTAKER Daniel Carter

ADDRESS 716 Pa Ave

3-1930 C. HAMPSON JONES, M. D. Registrar

Cor.—10-10-29—A Co.—100 Bks.

(John W. Beard)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59065

CERTIFICATE OF DEATH

194 E 59065

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St., 13-59 Ward)

2-FULL NAME J. W. Beard

(a) RESIDENCE NO. Lincoln St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Ada C

6 DATE OF BIRTH (month, day, and year) Dec 7 1864

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
65	66	7	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Ret'd
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Dr. J. W. Beard

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER L. Mussett

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant J. W. Beard
(Address)

15 Filed ..... 1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dehydration
Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. A. Kelly, M. D.

July 2 1930 (Address) 1609 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bath Cemetery	7/4 1930
20 UNDERTAKER J. E. Cook	ADDRESS 121 St Paul

Spec.—1-30—M. & T.—250 Blks.

E 59066

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59066

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mt Hope Retreat

CITY OF BALTIMORE: (NO. 9663 ST.) WARD)

2-FULL NAME Adam J. Parr

(a) RESIDENCE NO. Mt Hope Retreat ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa F Parr

DATE OF BIRTH (month, day, and year) May 23, 1868

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	2	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 8 0

(c) Name of employer Unknown 8 0

BIRTHPLACE (city or town) Baltimore

(State or country) Md

10 NAME OF FATHER John Georg Parr

11 BIRTHPLACE OF FATHER (city or town) Hukelheim

(State or country) Germany

12 MAIDEN NAME OF MOTHER Eva K. Ries

13 BIRTHPLACE OF MOTHER (city or town) Oberweidenthal

(State or country) Germany

Informant Mt Hope Retreat

(Address) Mt Hope Retreat

Filed 3 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21. 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to July 21, 1930, that I last saw him alive on July 21, 1930, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH was as follows: Chr Interstitial Nephritis

Atrm

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Manic-Depressive Psychosis

(duration) 23 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical

(Signed) Milton P. Hall, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 7/24/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

pec.—1-30—M. & T.—250 Bks

E 59067

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59067

CERTIFICATE OF DEATH.

65

REGISTERED NO. 27-48

1-PLACE OF DEATH Union Memorial Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST. 27-48 WARD)

2-FULL NAME Mr Walter McNamara

(a) RESIDENCE NO. 403 Charles Oak Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 4 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) May 16, 1909

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
21	21	2	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Washington, D. C.

10 NAME OF FATHER Andrew McNamara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Foxburg Pa.

12 MAIDEN NAME OF MOTHER Janet Ella Leitch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

Informant (Address) Mrs Mc 403 Charles Oak Ave, Baltimore Md

Filed 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23-30

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to July 23, 1930, that I last saw h alive on July 22, 1930, and that death occurred, on the date stated above, at 9:40 (Day or Night) A.m.

The CAUSE OF DEATH* was as follows:

Lymphoid Leukemia

(duration) — yrs. 4 mos. 8 ds.

CONTRIBUTORY (Secondary) Anemia, secondary

(duration) yrs. 2 mos. 8 ds.

18 Where was disease contracted if not at place of death? 403 Charles Oak Ave. City.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Course.

(Signed) Francis N. Gluck, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

20 UNDERTAKER Wm Cook

DATE OF BURIAL 7/26 1930

ADDRESS 1217 E Pratt St

Spec.—1-30—M. & T.—250 Bks.

E 59068 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59068

CERTIFICATE OF DEATH.

26-2 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3701 E Lombard ST. WARD)

2-FULL NAME Ernest Knoche

(a) RESIDENCE NO. 3701 E Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Knoche

DATE OF BIRTH (month, day, and year) Dec 5 1850

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	7	17	

OCCUPATION OF DECEASED Park Police

(a) Trade, profession or particular kind of work 61

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 10 yrs

(c) Name of employer Balto City

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Susan Knoche

(Address) 3701 E Lombard

Filed ..... 19 C. HAMPSON JONES, M. D., Registrar.

23 1930 Pay RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22. 1930

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1930, to July 22, 1930, that I last saw h.. alive on July 22, 1930, and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Samuel B. Wolfe, M. D.

7/23 1930 (Address) 1331 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel

DATE OF BURIAL July 25 1930

20 UNDERTAKER John Merics

ADDRESS 28 Orleans

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59069

CERTIFICATE OF DEATH

113 E 59069

REGISTERED NO. 8-16

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 N. Madeira ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Maurice Seubert

(a) RESIDENCE NO. 1522 N. Madeira ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of (single)

DATE OF BIRTH (month, day, and year) July 31, 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	23	

OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER George Christian Seubert

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Gladys Elliott

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

Informant Gladys Elliott Seubert

(Address) 1522 N Madeira St

Filed 3 1930 G. HAMPSON JONES, M. D.

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1930

17

I HEREBY CERTIFY, That I attended deceased from July 17, 1930, to July 23, 1930, that I last saw him alive on July 23, 1930 and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Victor Goldberg, M. D.

July 23, 1930 (Address) 1524 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL July 25 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eutaw

pec.—1-30—M. & T.—250 Bks

E 59070

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59070

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1818 W Baltimore St. (ST.) 19-27 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Shaw

(a) RESIDENCE NO. 1818 W Baltimore St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of George L. Shaw

DATE OF BIRTH (month, day, and year) April 9/1858

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	3	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Caleb Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co Md

12 MAIDEN NAME OF MOTHER Margaret Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

Informant George L. Shaw
(Address) 1818 W Baltimore St

C. HAMPSON JONES, M. D.
Registrar

Rec'd ..... 19 .....

3-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23/30

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1930, to July 23, 1930, that I last saw h.. alive on July 22, 1930, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Hemiplegia for

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Foran M. D.

, 19 30 Address 612 2040

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	July 25 1930
20 UNDERTAKER Harry H Armacost	ADDRESS 4204 Ridgewood Ave

Cor.—10-10-29—A Co.—100 Bks.

Percy Hancock

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59071

CERTIFICATE OF DEATH

195

E 59071

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Memorial Hospital St., 15-58 Ward)

2-FULL NAME Percy Hancock

(a) RESIDENCE NO. 2814 Kate ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie Hancock (nee Tomlinson)

6 DATE OF BIRTH (month, day, and year) Sept. 21, 1897

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	32	10	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va.

PARENTS

10 NAME OF FATHER A. L. Hancock

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Lucy Fontz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Mrs. Elsie T. Hancock
(Address) 2814 Kate Ave.

E. HAMPSON JONES, M. D. Registrar

3 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22-1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by lightning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

7/23, 1930 (Address) 1632 Ridgewood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Roanoke Va.

DATE OF BURIAL 7/23 1930

20 UNDERTAKER Harry A. Mitzke, 4101

ADDRESS Edmondson Ave.

Rec.—2-29-28—L. F. S.—500 Bks.

E 59072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

72 E 59072

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2202 Maryland Ave. ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry E. Godwin

(a) RESIDENCE NO. 2202 Maryland Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanor M.(nee Woolsey)

DATE OF BIRTH (month, day, and year) April 5, 1874

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	3	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer) 11 01

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER James Godwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant George Wayson

(Address) 2441 N. Charles St.

C. HAMPSON JONES, M. D. Registrar

By

JUL 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22-30

17 I HEREBY CERTIFY, That I attended deceased from July-1-, 1918, to July-22, 1930 that I last saw h. alive on July-21-, 1930 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia -

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia -

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Maurice Stark M. D.

7-23 1930 Address 8062 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 7/25/30

20 UNDERTAKER Harry A. Mitzke, 4101 Edmondson Ave.

ADDRESS

Spec.—8-16-29—L. F. S.—100 Bks.

E 59073

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59073

REGISTERED NO. 57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3326 Ellerslie Ave. ST., 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles E. Hamilton

(a) RESIDENCE NO. 3326 Ellerslie Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 4 mos. 7 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Ellen Walsh

DATE OF BIRTH (month, day, and year) March 16, 1860

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	4	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer) Maryland Meter

(c) Name of employer Company

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER James B. Hamilton

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Jane Reilly

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

Informant Cornelius J. Hamilton

(Address) 625 University Parkway

Filed 7-31-1930 G. HAMPSON JONES, M. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1930, to July 23, 1930, that I last saw h— alive on July 21, 1930 and that death occurred, on the date stated above, at 7.00 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 6 mos. 23 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine etc

(Signed) Eugene P. Pearson M. D.

July 25 1930 (Address) 6-14 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 7/25 1930

20 UNDERTAKER Henry W. Spears and Son

ADDRESS 805 N. Calvert

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59074

E 59074

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 Edmonson ave. ST., 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Morris

(a) RESIDENCE No. 1521 Edmonson ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Child

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year): July 30 - 1925

8 AGE: Years 4; Months 11; Days 29; If LESS than 1 day, hrs or min

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balt. Md

10 NAME OF FATHER: Thomas Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Alice Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

Informant (Address): Elsie Ford 1521 Edmonson Ave

Filed 3 1930 19 C. HAMPSON JONES, M. D., Registrar By RRH.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/23 1930

17 I HEREBY CERTIFY, That I attended deceased from July 22nd, 1930, to July 23rd 1930.

that I last saw him alive on July 23rd. 1930

and that death occurred, on the date stated above, at 6.00 p m

The CAUSE OF DEATH* was as follows:

Acct. Dilation of the heart of unknown origin

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklin st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Int. Auburn Cem. DATE OF BURIAL: July 24 1930

20 UNDERTAKER: Geo. H. Holland ADDRESS: 1318 N. Eutaw

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59075

CERTIFICATE OF DEATH

129

E 59075

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3877 Sixth St. (W.) 15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John F. Tully

(a) RESIDENCE NO. 3877 Sixth St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura Tully

DATE OF BIRTH (month, day, and year): —— 1872

AGE: Years 58 | Months — | Days — | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer): Stationery

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: William Tully

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Berry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

Informant: Laura Tully

(Address): 3877 Sixth St.

FILED JUL 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 21, 1930

that I last saw him alive on July 20, 1930

and that death occurred, on the date stated above at 8 A. m.

The CAUSE OF DEATH was as follows:

Apoplexy

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Kyle Jenner M. D.

7-23-30 (Address) 1 Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mutual Cem

DATE OF BURIAL: 7/24/1930

20 UNDERTAKER: J. F. Tully Sons

ADDRESS: 131 W. Lexington St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59076

CERTIFICATE OF DEATH

E 59076

167-001

REGISTERED NO. 27-44

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. 2217 Hamilton St., Ward)

2-FULL NAME Clara Milburn

(a) RESIDENCE NO. 2217 Hamilton St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Married

5a If married, widowed or divorced
HUSBAND of (or) WIFE of John B. Milburn

6 DATE OF BIRTH (month, day, and year) — — 1887

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	44	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John A. Lacks

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary A. Evans

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Mrs. J. Milburn
(Address) 2217 Hamilton

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar
JUL 3 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: (Hon. Comp. Mentus.)
Suicide Ill Gas Poisoning
(duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY Asphyxia.
(Secondary)
(duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted — —
If not at place of death?
Did employment precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Autopsy

(Signed) G. C. Stadler, M. D.
7/31 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

20 UNDERTAKER J. F. Lahey & Sons

DATE OF BURIAL 7/24 1930

ADDRESS 1314 Light St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59077

CERTIFICATE OF DEATH

17 E 59077

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mrs. V. Brito Ward 45762 (Street)

2-FULL NAME William John Hammett

(a) RESIDENCE NO. 3504 Calloway Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Elsie Pearl Hammett

6 DATE OF BIRTH (month, day, and year) Oct 1 1871.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	58	9	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9 BIRTHPLACE (city or town)
(State or country) Illinois

PARENTS

10 NAME OF FATHER Alfred Hammett

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Elsie P. Hammett
(Address) 3504 Calloway

15 Filed JUL 24 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest find that said deceased came to death
(autopsy or inquiry)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Suicide. Hemorrhage due to pistol wound of brain (duration) yrs. mos. 2 hours

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Blanchard Leech M. D.

July 23 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mont. Co. Md. Lot Friedenbaum

DATE OF BURIAL July 24 1930

20 UNDERTAKER J. J. Fickus & Sons

ADDRESS Catonsville

Spec.—1-30—M. & T.—250 Blks

E 59078 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 59078

CERTIFICATE OF DEATH.

REGISTERED NO. 25-32

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2332 Annapolis Road ST. WARD

2-FULL NAME Samuel Robert Monroe

(a) RESIDENCE NO. 2332 Annapolis Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Townsend Monroe

DATE OF BIRTH (month, day, and year) Feby 3 1855

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	5	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) Broker

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Prince Georges Co Md

10 NAME OF FATHER Thomas J. Monroe

11 BIRTHPLACE OF FATHER (city or town) (State or country) P.G. Co Md

12 MAIDEN NAME OF MOTHER Margaret Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Kate T. Monroe

(Address) 2332 Annapolis Road

Filed JUL 24 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1930, to July 22, 1930,

that I last saw him alive on July 22, 1930,

and that death occurred, on the date stated above, at 11.59 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Embolism.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis c angina (duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs.

(Signed) Thaweem L. Wheeler M. D.

, 19 (Address) 2910 Hollins Ferry Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL July 26 1930

20 UNDERTAKER D. J. Tickner & Son

ADDRESS Baltimore

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59079 — 19 — E 59079

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 30 E. Lanvale St. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Dif

(a) RESIDENCE NO. 30 E. Lanvale St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND (or) WIFE William Dif

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country) Md

PARENTS

10 NAME OF FATHER Julius Goldman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Bettie Hackerman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Mary Goldman
(Address) 1439 E. Balto St

15 Filed 24 1930 19 — Roy JONES M Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to Gun Shot wound in Chest Heart Shock while.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Enteritis July 23 — Homicide

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? —

(Signed) W. J. Kelly, M. D.

July 22 1930 (Address) 1637 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem. DATE OF BURIAL July 22 1930

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59080

CERTIFICATE OF DEATH.

90 E 59080

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital (St.) 13 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Soloman Rubenstein

(a) RESIDENCE No. 2106 E. Baltimore St. (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Lohie Rubinstein

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Harness

(b) General nature of industry, business, or establishment in which employed (or employer): Maker

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

Informant: A. J. Rubinstein

(Address) 2106 E. Balto St

Filed JUL 24 1930, 19 — HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1930

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to July 23, 1930

that I last saw h[illegible] alive on July 23, 1930

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Auricular fibrillation

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rodedale

DATE OF BURIAL: July 24, 1930

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 Eastern Ave

spec.—1-30—M. & T.—250 Blks.

E 59081 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59081

CERTIFICATE OF DEATH. 44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 30 WARD)

2-FULL NAME Elizabeth Hamburger

(a) RESIDENCE NO. 2 W. Lee Ave Townsend ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of Andrew L. Hamburger

DATE OF BIRTH (month, day, and year) Jan 2nd 1859

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	5	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs Irene L. Weiss

(Address) 2nd or Glen Burnie

Filed 4 1930 C. HARRISON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1 , 1930, to July 23 , 1930,

that I last saw her alive on July 23 , 1930,

and that death occurred, on the date stated above, at 6:10 a. m.

The CAUSE OF DEATH* was as follows:

General abdominal Carcinomatosis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of July 17. 1930

Was there an autopsy? No

What test confirmed diagnosis? Laparotomy

(Signed) W. H. Varney, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	July 26 1930
20 UNDERTAKER E. Schlosman & Son	ADDRESS 1039 Hanover

pec.—1-30—M. & T.—250 Bks

59082

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1930 E 59082

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 132 S. Ellwood ave (ST.) 1-2 (WARD)

2-FULL NAME Emma D. Overcash

(a) RESIDENCE No. 132 S Ellwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

If married, widowed, or divorced (or) WIFE of Thomas Overcash

DATE OF BIRTH (month, day, and year) Dec 6-1854

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	8	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) S. Carolina

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

Informant Mrs Helen Overcash

(Address) 132 S. Ellwood ave

Filed JUL 24 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22. 1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 22, 1930

that I last saw her alive on July 22, 1930

and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Heat - Prostration

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John F. Dennis M. D.

July 23 1930 (Address) 26 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn

DATE OF BURIAL July 24, 1930

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59083

CERTIFICATE OF DEATH

101 601

E 59083

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., Ward) 7-24-30

2-FULL NAME Charles Boswell.(C)

(a) RESIDENCE NO. Key Highway & Covington St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	50	---	------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. F.D. S.D.
(Address)

15 Filed JUL 24 1930 C. Hayden Jones, M. D. Registrar
Morgue.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy.
Lobar Pneumonia.
Oedema of the Brain.
(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Key Highway.
Did an operation precede death? No. Date of
Was there an autopsy? Yes.
What test confirmed diagnosis? Autopsy & Inquiry

(Signed) Otto M. Bernhardt, M. D.
7/21, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND
DATE OF BURIAL: JUL 23 1930 19

20 UNDERTAKER: Commissioner of Health.
ADDRESS

Per. Wm. E. WOODALL.

ec.—1-30—M. & T.—250 Bks

E 59084 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59084

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp. ST. 5-8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Marshall

(a) RESIDENCE NO. 512 Ashland ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

If married, widowed, or divorced HUSBAND of or) WIFE of unknown

DATE OF BIRTH (month, day, and year) unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lt

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

Informant

(Address)

Filed JUL 24 1930 H. A. Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/12/30

17 I HEREBY CERTIFY, That I attended deceased from 6/30, 1930, to 7/12, 1930, that I last saw h alive on 7/12 1930, and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Post operative)

(duration) ..... yrs. ..., mos ..... ds.

CONTRIBUTORY (Secondary) Appendectomy

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 7/1/30

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) B Hawes, M. D.

7/13, 1930 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS JUL 23 1930

... ST & WOODAL...

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59085

CERTIFICATE OF DEATH.

90 E 59085

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 Lloyd ST. 3-5 WARD)

2-FULL NAME Morris Goldstein

(a) RESIDENCE NO. 21 Lloyd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Ida

DATE OF BIRTH (month, day, and year) 1852

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Rud Goldstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Mrs I Goldstein
(Address) 2521 Druid Southern Ave

C. HARRISON JONES, M.D.
JUL 24 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24th 1930

17

I HEREBY CERTIFY, That I attended deceased from July 22nd, 1930, to July 24th, 1930, that I last saw h.. alive on 23rd, 1930, and that death occurred, on the date stated above, at 1a a. m.

The CAUSE OF DEATH* was as follows:

Cardio vascular disease,

due to old age.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation,

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + physical

(Signed) Morris Goldstein, M. D.

7/24 1930 (Address) 120 Forsyth St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Detrw Southern Ave

DATE OF BURIAL 7/24 1930

20 UNDERTAKER Sol Lurman + Bro

ADDRESS 1127 E Balto St

pec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59086

CERTIFICATE OF DEATH.

100-001

E 59086

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 S. East ave ST. 26-1 WARD)

2-FULL NAME Jeanette Link

(a) RESIDENCE NO. 911 S. East ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of George Link

DATE OF BIRTH (month, day, and year) Aug. 12-1847

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	11	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Christian Bechtold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

Informant Katherine Morgan

(Address) 911 S. East Ave

FILED JUL 4 1930 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22-1930

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to July 22, 1930.

that I last saw her alive on July 22, 1930,

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Senilis marasmus

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Phys. examenation.

(Signed) Jos. A. Rosenblatt, M. D.

7/29 1930 (Address) 3018 O'Donnell St, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL July 25 1930

20 UNDERTAKER George W. Sinkler

ADDRESS 1737 E. Eager St.

pec.—8-16-29—L. F. S.—100 Bks.

E 59087

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

71-001

E 59087

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 E. Fort Ave ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rita J. Katoski

(a) RESIDENCE NO. 1034 E. Fort Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 5 - 1929

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		9	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General natare of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

BIRTHPLACE (city or town) Balto
(State or country) Md.

10 NAME OF FATHER Walter J Kotoski

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Jeannette Rooth

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

Informant Jeannette Katoski

(Address) 1034 E. Fort Ave

4 1930 REGISTERED BY [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23-30

17 I HEREBY CERTIFY, That I attended deceased from July 22 19 30 to July 23 19 30,
that I last saw her alive on July 23 19 30
and that death occurred, on the date stated above, at 6.30 P. m.
The CAUSE OF DEATH* was as follows: Meningitis

(duration) yrs. mos. 4 da.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal Fluid

(Signed) C. Addy Lynch, M. D.

7/31/30 (Address) 1 E. Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL 1/24 1930.

20 UNDERTAKER C. Hunt

ADDRESS 2405 Eutaw

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59088

CERTIFICATE OF DEATH.

161-08

E 59088

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1405 Orington ST. 24-33 (WARD)

2-FULL NAME David Irving Johnson

(a) RESIDENCE NO. 1405 Orington ST, WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9hrs How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m.	w	infant

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) July 23 1930

AGE	Years	Months	Days	If LESS than 1 day, 9 hrs. or min.
9 hours				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work no

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto. Md
(State or country)

10 NAME OF FATHER Howd. D. Johnson

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER Elsie Robinson

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

Informant Howard D. Johnson

(Address) 1405 Coington St.

Filed J. 24 1930 . 19 Per C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) J. 24. 30.

17

I HEREBY CERTIFY, That I attended deceased from J. 23. 30. , 19 , to J. 24. 30 , 19 ,

that I last saw h in alive on J. 24. 30 , 19 ,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Premature delivery

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Philip B. Fowler, M. D.

J. 24. 30 , 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL July 24 1930

UNDERTAKER C. L. and Eva E. Frat

ADDRESS

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59089

CERTIFICATE OF DEATH

E 59089

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. West Balto Gen Hosp St., Ward)

2-FULL NAME Concetta Battaglia

(a) RESIDENCE NO. 2818 Lawrence St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Battaglia

6 DATE OF BIRTH (month, day, and year) Aug 31, 1910.

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	20	10	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John Libuto

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Maria Battaglia

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Anthony Battaglia
(Address) 2818 Lawrence St

15 Filed 7-24-1930 19 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide
Hemorrhage due to fatal wound of abdomen (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Necropsy
(Signed) H. E. Smith, M. D.
July 22 (Address) Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 7/25 1930

20 UNDERTAKER Penning Son

ADDRESS 1150 Belair

Cor.—10-10-29—A Co.—100 Bks.

59090

HEALTH DEPARTMENT—CITY OF BALTIMORE

59090

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 110 N Port St. 6-10 Ward)

2-FULL NAME Mary Milchling

(a) RESIDENCE NO. 119 N Port St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Milchling

6 DATE OF BIRTH (month, day, and year) Aug 5, 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) .....
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Casper B. Vogel

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Barber

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Katherine Vogel
(Address) 110 N. Port St

15 Filed ..... C. HAMPSON JONES, M. D., Registrar
4 1930 Rec

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and Autopsy (Inquest, autopsy or inquiry) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? History

(Signed) G E Gladd, M. D.

(Address) 1436 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL July 26 1930

20 UNDERTAKER Frank V. Pipitone

ADDRESS 2918 E. Balto St

Spec.—1-30—M. & T.—250 Bks.

E 59091 HEALTH DEPARTMENT—CITY OF BALTIMORE VE 59091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 34

CITY OF BALTIMORE: (NO. 70-69 ST., WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Catanese

(a) RESIDENCE NO. 2328 W Lexington ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W. C.	Married

If married, widowed, or divorced
HUSBAND) of Unknown
(or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 12, 1874

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
55 6	—	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) — ?

(c) Name of employer ?

BIRTHPLACE (city or town) Unknown
(State or country) Italy

10 NAME OF FATHER Santi Catanese

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa ?

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Italy

Informant Mrs. Rosa
(Address) Baltimore City Hosp

Filed ..... 19 HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22-30

17 I HEREBY CERTIFY, That I attended deceased from 8-10-, 1926, to 7-22-, 1930,
that I last saw him alive on 7-22-, 1930,
and that death occurred, on the date stated above, at 2 1/4 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of dorsal spine and right hip

(duration) Unknown yrs. Unknown mos. ..... da.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) ..... yrs. ..... mos. 7 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Unknown Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & X-ray

(Signed) Fred W. Dinkelacker, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL July 25 1930

20 UNDERTAKER Frank V. Capitone

ADDRESS 2518 E. Baltimore St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59092

CERTIFICATE OF DEATH.

185 E 59092

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital Wilkins & Gatewood Avenues ST. 15-65 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Alice Winchester

(a) RESIDENCE NO. 2516 Talbott Rd. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj Winchester

6 DATE OF BIRTH (month, day, and year) Dec 29, 1855

7 AGE 74 Years Months 6 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. J. Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs William Winchester
(Address) 2516 Talbott Rd

15 Filed 2 4 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1930

17 I HEREBY CERTIFY, That I attended deceased from June 20 1930, to July 23, 1930, that I last saw her alive on July 22, 1930 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Fracture of Rt. hip
Fall down steps at home
(Accident)

(duration) yrs. mos 33 ds.

CONTRIBUTORY (Secondary) Hypostatic
Pneumonia (duration) yrs. mos. 3 ds.

Where was disease contracted if not at place of death? St. Agnes Hosp.

Did an operation precede death? no Date of

Was there an autopsy? no

What was confirmed diagnosis? Frac. Clavicle

(Signed) Fernando R. Buckley M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemy.

DATE OF BURIAL July 25 1930

UNDERTAKER J. D. Mitchell & Sons

ADDRESS 1900 Eutaw Place

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59093

CERTIFICATE OF DEATH.

49 ✓

E 59093

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2869 Woodbrook Ave ST.) 54 (WARD)

2-FULL NAME Benjamin Carroll Baxter

(a) RESIDENCE. No 2869 Woodbrook Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~Wife of~~) Bertha Tyng Baxter

6 DATE OF BIRTH (month, day, and year) May 4, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Derrick Engineer.

(b) General nature of industry, business, or establishment in which employed (or employer) Penna R.R.

(c) Name of employer Penna R.R. Co

9 BIRTHPLACE (city or town) Carroll County

(State or country)

PARENTS

10 NAME OF FATHER Wm Baxter

11 BIRTHPLACE OF FATHER (city or town) Carroll Cty

(State or country) Md

12 MAIDEN NAME OF MOTHER Virginia Wood

13 BIRTHPLACE OF MOTHER (city or town) Carroll Cty

(State or country) Md

14 Informant Mrs Bertha Tyng Baxter

(Address) 2869 Woodbrook Ave

15 Filed ....., 19.. C. HARRISON JONES, M. Registrar.

JUL 24 1930 By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23/1930.

17 I HEREBY CERTIFY, That I attended deceased from June 26 1930. to July 23 1930

that I last saw h alive on July 23 1930.

and that death occurred, on the date stated above, at 10.23 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fred A Hoffheimer M. D.

, 19 (Address) 1807 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemy.	July 26 1930

20 UNDERTAKER Chas O. Mitchell & Sons ADDRESS 1900 Eutaw St

Rose D. Bandell

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59094

CERTIFICATE OF DEATH.

90 ✓ E 59094

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1307 E. Federal ST. 9-18 WARD)

2-FULL NAME Rose D. Bandell

(a) RESIDENCE No. 1307 E. Federal ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Augustus G Bandell

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 62				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of Industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Md

10 NAME OF FATHER Frederick Buchstein

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary C. Rittle

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

Informant Mr. Augustus G. Bandell

(Address) 1307 E. Federal St.

Filed ..... 19 .....

C. HAMPSON JONES, M. D.
Registrar

By ..... R.H.C.

7-4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1927, to July 22 1930,

that I last saw h— alive on July 22, 1930,

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency Regurgitation

(duration) 2 yrs. — mos — da.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 6 yrs. 3 mos. da.

18 Where was disease contracted —
If not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. F. Blake — M. D.

19 (Address) 20 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Mount Cemetery	July 25 19 30
20 UNDERTAKER John O. Mitchell & Son	ADDRESS 1300 Eutaw Pl

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

59095 E 59095

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Preston ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Campbell

(a) RESIDENCE NO. 508 Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter Campbell

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Ocala Cuba

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

Informant: Mrs Flora Lee

(Address) 230 E Preston St

Filed 7-24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20/30

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 20 1930, that I last saw her alive on July 20, 1930, and that death occurred, on the date stated above, at 5.40 P.M. E.S.T.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Harry E. Wagner M. D.

7-24 1930 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Cem

DATE OF BURIAL: 7-24 1930

20 UNDERTAKER: Daniel Leyton

ADDRESS 916 Pa Ave

spec.—1-30—M. & T.—250 Blks.

E 59096

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59096

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Stallman

(a) RESIDENCE NO. 1200 Valley St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Mar 15, 1865

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Penna.
(State or country)

10 NAME OF FATHER Girard Stallman

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Josephine Will

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Informant Good Mother Joseph
(Address)

Filed 7-24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/22/30

17 I HEREBY CERTIFY, That I attended deceased from 7/21, 1930, to 7/22, 1930,
that I last saw h alive on 7/21, 1930,
and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 da.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Bernard Wolf M. D.

7/23/30 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy [redacted]	July 25 1930
20 UNDERTAKER Rita Wiedefeld	ADDRESS 914 Gremmt Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59097

E 59097

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1317 Valley (St.) (9-18 WARD)

2-FULL NAME George Isbell

(a) RESIDENCE NO. 1317 Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

1941

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

4 COLOR OR RACE: white

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Myers

DATE OF BIRTH (month, day, and year): Feb 22 1853

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	4	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Germany

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

Informant: Mrs. Carroll McInnis

(Address) 1317 Valley St

Filed 4 1930

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1930

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 23, 1930, that I last saw him alive on July 22, 1930, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Not definite mos ds.

CONTRIBUTORY (Secondary) Heart prostration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Hayden, M. D.

7/24/1930 (Address) 1216 E. Caroline at

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: July 25 1930

20 UNDERTAKER: Rita Friedefeld

ADDRESS: 914 Gremmt Pl

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59098

CERTIFICATE OF DEATH

E 59098

REGISTERED NO. 1134

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 643 W La Fayette St., 17-24 Ward)

2-FULL NAME Wm Jones

(a) RESIDENCE NO. 643 W La Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	1	1	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Willie Jones
11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)
12 MAIDEN NAME OF MOTHER Sarah Pryer
13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Sarah Jones
(Address) 643 W La Fayette St

15 Filed ....., 19.....

C. HAMPSON JONES, M. D.

JUL 24 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted? Home
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Negative

(Signed) July 23 1930 Chas Hirsch Brown, M. D.
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL July 24, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N Schroeder St

1-30—M. & T.—100 B—50L

E 59099

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59099

CERTIFICATE OF DEATH

1-PLACE OF DEATH Pronounced dead at Franklin Sq. Hosp. REGISTERED NO. .....

CITY OF BALTIMORE: (No. 37 S. Stockton ST. 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Parks, Jr.

(a) RESIDENCE NO 37 S Stockton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Parks

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER John Parks Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Fannie Futch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

Informant Mr. Meteno Futch

(Address) 37 S Stockton

Filed ....., 192 C. HAMPSON JONES, M. D.

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Heat

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. H. Bromole, M. D. Coroner

7/22, 1930 (Address) 3601 Third St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

UNDERTAKER Mrs. Katie R. Williams

DATE OF BURIAL July 24, 1930

ADDRESS 322 N. Schroeder St.

7-1-1053

pec.—2-29-28—L. F. S.—500 Bks.

Redmon

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59100

CERTIFICATE OF DEATH

129 E 59100

REGISTERED NO. 13-52

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE; (No.) 3317 Faine ST. (WARD)

2—FULL NAME Lillie V. Redmond.

(a) RESIDENCE NO. 3317 Faine ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. J. Redmond

DATE OF BIRTH (month, day, and year): June 11 1859

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: Thomas Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co. Md.

12 MAIDEN NAME OF MOTHER: Sarah Griswell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co. Md.

Informant: Wm. J. Redmond

(Address) 3317 Faine St

Filed JUL 24 1930 HERMAN JONES, M.D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23/30.

17 I HEREBY CERTIFY, That I attended deceased from July 13 1930 to July 23 1930,

that I last saw her alive on July 22nd 1930

and that death occurred, on the date stated above, at 5 30 A.M. D.S.T.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) [illegible] M. D.

7/23 1930 (Address) 826 W Fayette St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cem Hampden	July 25, 1930
20 UNDERTAKER	ADDRESS
Walter Davis	3418 Chestnut Ave

St Paul St

Spec.—1-12-23—M&T—500 Blks.

E 59101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

61-0d

E 59101

1-PLACE OF DEATH West Balto. Genl. Hospital

CITY OF BALTIMORE: (No. 20-69 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby boy Disney

(a) RESIDENCE, NO. 2759 W. Fairmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1/240 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	infant

6 If married, widowed, or divorced HUSBAND of (or) WIFE of infant child 9

DATE OF BIRTH (month, day, and year) 7-23-30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	10 minutes only.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) West Balto Genl. Hosp

10 NAME OF FATHER John Disney

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Eva Peters

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md (State or country)

Informant West Balto. Genl. Hospital. (Address)

7-24 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23-1930

17 I HEREBY CERTIFY, That I attended deceased from birth 7-23-30 (10 50 P.M.) to death at 11 P.M. 7/23/1930.

that I last saw him alive at 11 P.M. 7-23-, 1930,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

premature birth
being a 5½ mos. foetus

10 minutes, (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? delivery Date of 7-23-30

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) R. G. Griesemer, M. D.

7-23 1930 (Address) West Balto Genl. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Balto Gen. Hospital

DATE OF BURIAL 19

UNDERTAKER Commissioner Health.

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

E 59102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 59102

REGISTERED NO. 2

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 504 Carrol St. 11-24 Ward)

2-FULL NAME Lula Turner

(a) RESIDENCE NO. 504 Carroll St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Co	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Pulmonary Phthisis

(duration) 1 yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Albert Hirsch, M. D.
Coroner
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

HAMPSON JONES, M. D. Registrar

UNIVERSITY OF MARYLAND
JUL 24 1930

L 24 1930

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59103

CERTIFICATE OF DEATH.

19 E 59103

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 503 N. Calhoun st. (ST.) 19-26 (WARD)

2-FULL NAME Jessie Octavia Dudley

(a) RESIDENCE NO. 503 N. Calhoun st. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(if non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Negro	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) May, 13th. 1989

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	1	2	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Chas. A. Dudley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Jessie E. DeShields

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

Informant Chas. A. Dudley

(Address) 503 N. Calhoun st.

7-24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23- 19 30

17 I HEREBY CERTIFY, That I attended deceased from July 23rd. 19 30. to July 23rd. 19 30.

That I last saw her alive on July 23rd, 19 30

and that death occurred, on the date stated above, at 6;30 p.m.

The CAUSE OF DEATH* was as follows:

Heat Exhaustion (Sun Stroke)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Malnutrition

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklin st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem.

DATE OF BURIAL 7-24 1930

UNDERTAKER Chas E. Cooper

ADDRESS 517 N. Calhoun st

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59104

CERTIFICATE OF DEATH

90

E 59104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 517 W Biddle St. 17-24 (Ward)

2-FULL NAME Rachel Taylor

(a) RESIDENCE NO. 517 W Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1837

7 AGE: Years 103 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Md
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)
(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) ?

14 Informant Records Aged Home 5-10-38 Biddle

15 Filed ..... 19.... HARRY JONES, M. D. Registrar

L 24 1938

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1936

I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, au topsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) July 23 1936 M. D.

(Address) Corner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	July 26 36
20 UNDERTAKER	ADDRESS
Samuel E. Stuckey	1178 W Biddle

spec.—8-16-29—L. F. S.—100 Blks.

E 59105

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 ✓ E 59105

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 McMechen ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME No Name

(a) RESIDENCE NO. 507 McMechen ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 7-24-30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				45

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) 507 McMechen
(State or country)

10 NAME OF FATHER Roland Heller

11 BIRTHPLACE OF FATHER (city or town) Columbia
(State or country) S C

12 MAIDEN NAME OF MOTHER Elizabeth Hanlon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Columbia S. C.

Informant

(Address)

24 1930 19 [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24-30

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1930, to July 24, 1930, that I last saw her alive on July 24, 1930 and that death occurred, on the date stated above at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Injury to Mother

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. J. Woolridge, M. D.

7-24 1930 (Address) 703 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS JUL 24 1930

UNIVERSITY OF MARYLAND

pec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59106

CERTIFICATE OF DEATH.

43 E 59106

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3810 Foster Av ST. 46-31 WARD)

2-FULL NAME Charles Kamka

(a) RESIDENCE NO. 3810 Foster av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elizabeth Kamka

DATE OF BIRTH (month, day, and year) Apr 24/67

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	2	30	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) City 006

(c) Name of employer City Dept.

BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER Herman Kamka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lena

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Elizabeth Kamka

(Address) 3810 Foster av

Filed JUL 24 1930 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23/30

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1929 to July 23, 1930, that I last saw him alive on July 22, 1930, and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Microscope

(Signed) Frank G. Glenn, M. D.

July 27, 1930 (Address) 3244 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 7/26, 1930

20 UNDERTAKER Philip Herring

ADDRESS 206 Orleans St

per.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59107 ✓ E 59107

CERTIFICATE OF DEATH.

194

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4800 Frankford Av ST. 26-42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Sinners

(a) RESIDENCE NO. 4800 Frankford Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced (HUSBAND of (or) WIFE of) James R. Sinners

DATE OF BIRTH (month, day, and year) July 7 1888

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42		5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

031

BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER Chas. J. Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Mary Caulfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant James R. Sinners

(Address) 4800 Frankford Av

Filed 7-24 1930 HARRISON JONES, R. [signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22nd 1930

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1930, to July 22, 1930, that I last saw h alive on July 22 1930 and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) Heart Prostration

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Attended

(Signed) [signature], M. D.

7/25 1930 (Address) 330 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

20 UNDERTAKER Philip Herwig

DATE OF BURIAL 7/25 1930

ADDRESS 2016 Orleans St

Spec.—12-9-25—A Co.—200 Blks.

59108

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 E 59108

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave. St., 20-27 Ward)

2-FULL NAME William Twilley

(a) RESIDENCE NO. Home for the Aged of the M. E. Church

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mrs Anna May Twilley

6 DATE OF BIRTH (month, day, and year) Oct 24 1848

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	81	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Quantico

(State or country) Md.

PARENTS

10 NAME OF FATHER George Twilley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Elzey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Etta Cuddy

(Address) 400 N. Fulton Ave.

15 Filed JUL 24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Mch 16, 1930, to July 23, 1930, that I last saw h~~im~~ alive on July 22d, 1930, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Uraemia Coma

(duration) ✓ yrs. ✓ mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical methods

(Signed) George C. Shannon, M. D.

7/23, 1930 (Address) 700 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Oconoke City Md July 25 1930

20 UNDERTAKER George J. Smith — ADDRESS Hollins 1532

Spec—12-9-25—A Co—200 Blks.

E 59109

HEALTH DEPARTMENT—CITY OF BALTIMORE

23 E 59109

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2866 Jefferson St. St., 7-11 Ward)

2-FULL NAME Roberta J. Calhoun

(a) RESIDENCE NO. 2866 Jefferson St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas G. Calhoun

6 DATE OF BIRTH (month, day, and year): Sept. 21, 1869

7 AGE: Years 61 | Months 10 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER Julius Mathews

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Bayless

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant Kate Bayless

(Address) 2866 Jefferson St

Filed 7-24-1930 C. HAMPSON JONES, M. D. Registrar

By _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1929, to July 23d, 1930,

that I last saw h.e alive on July 22d, 1930,

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Arthritis

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Seibert, M. D.

7-23 1930 (Address) 711 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Bakers Cemetery Harford Co July 25 1930

20 UNDERTAKER — ADDRESS

Henry Tanning Sons Aberdeen Md

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59110

CERTIFICATE OF DEATH

E 59110

1-PLACE OF DEATH Dundalk. Md.

CITY OF BALTIMORE: (No.) 6512 Baltimore (St. and No.) Ave

REGISTERED NO. 100 16-36

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edward Garrett.

(a) RESIDENCE No. 6512 Baltimore St. Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2/1903.

7 AGE — Years: 26 Months: 10 Days: 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Sparrows Pt. Md. (State or country)

PARENTS

10 NAME OF FATHER John P. Garrett

11 BIRTHPLACE OF FATHER (city or town) Pa. (State or country) Dolphin Co.

12 MAIDEN NAME OF MOTHER Alice A. Myers

13 BIRTHPLACE OF MOTHER (city or town) Pa. (State or country) Dolphin Co

14 Informant John P. Garrett.

(Address)

Filed JUL 24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1930

17 I HEREBY CERTIFY, That I attended deceased from 7/10/1930 to 7/22/1930, that I last saw him alive on 7/22/1930, and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia,

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McCormick, M. D.

7/23/30 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: July 25 1930

20 UNDERTAKER: H. Sander Son — ADDRESS: 1710 Fleet St

Rec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59111 ✓ 49 E 59111

E 59111

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2304 E. Madison ST. 7-19 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME EMMA P. JOHNSON

(a) RESIDENCE NO. 2304 E. Madison ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of - - -

DATE OF BIRTH (month, day, and year) Sept. 8. 1830

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country)

10 NAME OF FATHER Richard Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Almira Fosler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

Informant: Miss Laura Gregory (Cousin

(Address) 2304 E. Madison St.

Filed 4-1930, 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1930, to July 21, 1930, that I last saw h[illegible] alive on July 20, 1930, and that death occurred, on the date stated above, at 1.10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of no.

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Alan B Lemmon M. D.

7/24/30 (Address) 718 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL July 25 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore & Broadway

C. ROBERT JONES, M. D.
SENIOR HOSPITAL

Spec.—1-30—M. & T.—250 Blks

E 59112

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59112

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp ST. 12-4-G WARD)

2-FULL NAME Baby Hushon (boy)

(a) RESIDENCE NO. Delta, Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

DATE OF BIRTH (month, day, and year) 7-5-30

AGE	Years	Months	Days	If LESS than 1 day, 9 hrs. or min.
	0	0	0	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Delta, Pa

10 NAME OF FATHER Joseph Hushon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Barton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Howard Bixtel

(Address) Parkton Md

Filed 4-1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24th 1930

17

I HEREBY CERTIFY, That I attended deceased from July 24th, 1930, to July 24th, 1930,

that I last saw him alive on July 24th, 1930,

and that death occurred, on the date stated above, at 2 P.M. D.S.T.

The CAUSE OF DEATH* was as follows:

Premature infant

9 hrs.

(duration) 0 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) (duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) Jesse J. Tyler, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkville Md

DATE OF BURIAL July 25th 1930

20 UNDERTAKER H. H. Hebb

ADDRESS Towson Md

dec.—1-30—M. & T.—250 Bks.

E 59113 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59113

CERTIFICATE OF DEATH.

REGISTERED NO. 100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2029 N Wolfe ST. (WARD) 8-17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME A. Philippina Frese

(a) RESIDENCE NO. 2029 N Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Christian L. Frese

DATE OF BIRTH (month, day, and year) Jan 23-1840

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	90	6		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Keck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Kuss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Miss Mary Frese

(Address) 2029 N Wolfe

Filed 4-1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23-1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 23, 1930, that I last saw h[illegible] alive on July 23, 1930, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) C P Roerling, M. D.

19 (Address) 1822 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel — DATE OF BURIAL Jan 26 1930

20 UNDERTAKER John Allred — ADDRESS 2008 Eutaw

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59114

CERTIFICATE OF DEATH

194 E 59114

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 232 S. Bond St 3-4 Ward)

2-FULL NAME Weronika Kmiotek

(a) RESIDENCE NO. 232 S Bond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Kmiotek

6 DATE OF BIRTH (month, day, and year) Jan 15 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	34	6	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Kmiotek

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Stella Kucharska
(Address) 232 S Bond

Filed ..., 19 THOMPSON JONES, Registrar

4 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Exhaustion

(duration) ..yrs. ..mos. 4 ds.

CONTRIBUTORY (Secondary) over work + Exposure

(duration) ..yrs. ..mos. 2 ds.

18 Where was disease contracted If not at place of death? Whitehall md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

19 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	July 26 1930

20 UNDERTAKER Martin W. C Duffy Lin ADDRESS 372 Arnold

Spec.—1-30—M. & T.—250 Bks.

E 59115

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59115

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary St. 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dugent

(a) RESIDENCE NO. 3345 Kennick Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Grace Dugent

DATE OF BIRTH (month, day, and year) Nov. 9, 1895.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	8	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad supt. 078

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. R. & E. Co.

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Harry Dugent.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Mrs. Grace E. Dugent.

(Address) 3348 Kennick Rd.

1930 ..... 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 22, 1930, that I last saw him alive on July 22, 1930, and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Paroxysmal tachycardia (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon H. Norwood, M. D.

7/23/1930 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem.

DATE OF BURIAL 7/25/1930

20 UNDERTAKER Horace F. Burger

ADDRESS 3631 Falls Rd.

Spec.—1-12-23—M&T—500 Blks.

59116 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 59116

176

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Balto. Gen. Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 8-16 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Edna E. Cobb.

(a) RESIDENCE NO. 2421 Llewellyn Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Wm B Cobb

DATE OF BIRTH (month, day, and year) Dec 31 1707

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	6.	27.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ohio

10 NAME OF FATHER George Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Grace Perkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

Informant William B Cobb

(Address) 2421 Llewellyn Ave

Filed JUL 24 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1930

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to July 23, 1930, that I last saw h[illegible] alive on July 23, 1930, and that death occurred, on the date stated above, at 3 50 Am.

The CAUSE OF DEATH* was as follows:

Pelvic Peritonitis

(duration) yrs. 2 1/2 mos ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-21-30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Eshleman, M. D.

, 19 (Address) W. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 7/26 1930

20 UNDERTAKER Gilbert L Nilty for 1930 — ADDRESS Harford Ave

c.—2-29-28—L. F. S.—500 Bks.

E 59117 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59117

CERTIFICATE OF DEATH

REGISTERED NO. 74-80

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 N. Bond Street ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John A. Connelly

(a) RESIDENCE NO. 1728 N.Bond Street ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced
HUSBAND of (or) WIFE of Kate Connelly

6 DATE OF BIRTH (month, day, and year) 2/19,1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Martin Connelly

11 BIRTHPLACE OF FATHER (city or town) New Jersey
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Albaugh

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

Informant Miss Elizebeth Connelly
(Address) 1728 N. Bond Street

Date 4-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/23/30

17 I HEREBY CERTIFY, That I attended deceased from 7/20, 1930, to 7/23, 1930, that I last saw him alive on 7/23, 1930 and that death occurred, on the date stated above, at 5.10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia & Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N D Date of

Was there an autopsy? N

What test confirmed diagnosis? Signs & symptoms

(Signed) Jay A Rutledge, M. D.

, 19 (Address) 1623 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 7/26 1930

UNDERTAKER Albert L Wiltz 1606

ADDRESS Chester St

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59118 ✓ E 59118

CERTIFICATE OF DEATH

× 129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1321 Linden Ave (St.) 11-24 (Ward)

2-FULL NAME John L. Brinton

(a) RESIDENCE NO. 1321 Linden Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 8 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year) Nov 9 1903

7 AGE — Years 26 | Months 9 8 | Days 13 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shirt Presser
(b) General nature of industry, business, or establishment in which employed (or employer) Ott
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Shirmanstown Pa

10 NAME OF FATHER Jessie S. Brinton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Ethel McGuire
(Address) 1918 Locke St

Filed ..... 192 ..... Registrar HAMPSON JONES, M. D.

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) ... yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Kidney Function

(Signed) ... M. D.
(Address) July 24 1930 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL A. Jones Mechanicsburg Pa

DATE OF BURIAL July 24 1930

20 UNDERTAKER H. S. Gilson

ADDRESS H. S. Gilson

ec.—2-29-28—L. F. S.—500 Bks.

E 59119

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59119

CERTIFICATE OF DEATH

REGISTERED NO. 185

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. Homans Hospital ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lois Hager Fenton

(a) RESIDENCE NO. 1421 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced
HUSBAND of (or) WIFE of J. Howard Fenton

ATE OF BIRTH (month, day, and year) Jan 20 1858

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	4	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Bondsville
(State or country) Ohio

10 NAME OF FATHER William Hager

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) U. S. A.

12 MAIDEN NAME OF MOTHER Mary Lucie Fisher

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) U. S. A.

Informant Mrs Lucille Van Gulden
(Address) 1421 Bolton St.

Filed 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 5 1930 to July 24 1930.

that I last saw her alive on July 24 1930

and that death occurred, on the date stated above, at 10 a. m. (standard time)

The CAUSE OF DEATH* was as follows:

Bronchopneumonia - bilateral

CONTRIBUTORY (Secondary) Fracture rt. hip (duration) 3 wks. 2 mos. 2 ds.

(duration) 2 yrs. 2 mos. 19 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Rudolph J. Schork, M. D.

July 26, 1930 (Address) Homans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL July 26/1930

20 UNDERTAKER Stewart Memorial Co — ADDRESS Baltimore

Dr Grady 4218 Harford Rd

Rec.—1-30—M. & T.—250 Blks.

E 59120

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59120

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3008 Hoover Ave ST. 27-41 WARD

2-FULL NAME Elizabeth E Umspacher

(a) RESIDENCE NO. 3008 Hoover Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Wesley S Umspacher

DATE OF BIRTH (month, day and year) Oct 12, 1837

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
92	9	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER John Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eve Waldmyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs Eva Combs

(Address) 3008 Hoover Ave

HAMPSON JONES, M. D. Registrar

Filed 1930, 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22. 1930

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to July 22, 1930, that I last saw h[illegible] alive on July 22, 1930, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos 4 da.

CONTRIBUTORY (Secondary) Chronic Valvular Endocarditis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) L. L. Grady, M. D.

7-23 1930 (Address) Harford & Aberdeen Aves

*State the Disease Causing Death, or in deaths from Violent Causes, state (i) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glen Rock Pa

DATE OF BURIAL 7/25 1930

20 UNDERTAKER [illegible]

ADDRESS 1210 Gay St

...c.—1-30—M. & T.—250 Mbs

E 59121 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59121

118

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital 9-18 REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. (WARD)

2-FULL NAME Sarah Meitzel

(a) RESIDENCE NO. 1430 N Eden ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 17 67

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63		7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER Wesley Ainspacher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Eliz. Wolfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

Informant Husb. Friends.
(Address)

Filed 1930 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24-30

17 I HEREBY CERTIFY, That I attended deceased from 7-22, 1930, to 7-24, 1930, that I last saw h[illegible] alive on 7-24, 1930, and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction 2 days
(Umbilical Hernia, 35 yrs)
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Cirrhosis
(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) J Leyko, M. D.
7/24, 1930 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glen Rock Penna — DATE OF BURIAL 7/26/1930

20 UNDERTAKER Wm Cook 1217 — ADDRESS St Paul St

Campbell Hanover & Baltes

pec.—1-30—M. & T.—250 Bks.

E 59122

HEALTH DEPARTMENT—CITY OF BALTIMORE E 59122

CERTIFICATE OF DEATH.

24001

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 810 West Fayette St., WARD 23-32)

2-FULL NAME Clara Ea Lore

(a) RESIDENCE NO. 810 West Fayette Place WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	widow

If married, widowed, or divorced HUSBAND of or) WIFE of Chas H.

DATE OF BIRTH (month, day, and year) Unknown.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Wm L. Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Chas H. Long

(Address) 810 West Fayette St.

Filed 7-1930 C. HAMPSON JONES, M. D. Registrar

Pg.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1930

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to July 24, 1930, that I last saw her alive on July 24, 1930, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Clinical findings

(Signed) R. L. Campbell M. D.

7/24, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 7/26 1930

20 UNDERTAKER H. C. Cole

ADDRESS 247 St Paul

pec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59123

E 59123

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH U.S. Marine Hospital Baltimore, Md.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 11-21 WARD)

2—FULL NAME George W. Breaker

(a) RESIDENCE NO. 115 McCullough St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 11 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Aug. 15, 1859

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	11	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer Schr. Mable & Ruth

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Travers Breaker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George Co., Md.

12 MAIDEN NAME OF MOTHER Polly Rich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington, D.C.

Informant Records, U.S. Marine Hospital

(Address) Baltimore, Md.

Filed 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 16, 19 29, to July 23, 19 30

that I last saw h... alive on July 23, 19 30

and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Thrombosis, cerebral

(duration) yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) Gangrene, left leg - Myocarditis

Chr. Hypertension (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 7-23-30

Was there an autopsy? No

What test confirmed diagnosis Clinical & lab. findings

(Signed) Otis L. Anderson, M. D.

7/24, 19 30 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL July 25, 1930

20 UNDERTAKER E. Leroy Stafford, Inc. — ADDRESS 125 E. North ave.

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59124

CERTIFICATE OF DEATH

E 59124

1—PLACE OF DEATH

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.) 2754 Cecil Av ST., 9-46 (WARD)

2—FULL NAME Peter J. McCourt

(a) RESIDENCE NO. 2754 Cecil Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1868

AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	62			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER David McCourt

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mrs Peter McCourt

(Address) 2754 Cecil Av

C. HAMPSON JONES, M. D.
Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 22, 1930, that I last saw h alive on July 22, 1930 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Arthur C Manning M. D.

7/24 1930 Address) 800 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Woods — DATE OF BURIAL 7/25 1930

20 UNDERTAKER J. F. Schaefer — ADDRESS 1318 Light

59125

HEALTH DEPARTMENT—CITY OF BALTIMORE

59-002 E 59125

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH West Balto. Genl. Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. 27-11 WARD

CITY OF BALTIMORE: (NO.

2-FULL NAME Baby Boy Norton

(a) RESIDENCE NO. 4735 Alhambra Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	infant

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) July 18th 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
			6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) West Balto. Genl. Hosp. Balto., Md.

10 NAME OF FATHER George Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elsie Hooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

Informant (Address) Harry Norton 1918 Wilkens Ave

Filed 5-1930 19 (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 18th 1930, to July 24 1930, that I last saw h alive on July 24 1930 and that death occurred, on the date stated above, at 2.15 P.m.

The CAUSE OF DEATH* was as follows:

cyanosis from birth
congenital heart disease

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? delivery Date of 7-18-30

Was there an autopsy? - no

What test confirmed diagnosis?

(Signed) R. G. Griesemer M. D.

7/24 1930 (Address) West Balto Genl. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 7/25 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 Lafayette

...ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

138 E 59126

59126

CERTIFICATE OF DEATH

REGISTERED NO. 13-54

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. Homan's Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Shapiro

(a) RESIDENCE NO. 2238 Linden Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 42 ✓ mos. ✓ ds. How long in U. S., if foreign birth? 42 yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Shapiro

ATE OF BIRTH (month, day, and year) Sept 15, 1879

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
50	51	10	10	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

IRTHPLACE (city or town) (State or country) Russia ?

10 NAME OF FATHER Isiob Patticloff ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia ?

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia ?

Informant Solomon Shapiro

(Address) 2238 Linden Ave.

Filed ..... 19 C. HAMPSON JONES, Registrar

5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1930, to July 25, 1930

that I last saw h.er alive on July 25, 1930

and that death occurred, on the date stated above, at 12 54 A.m. (Dst.)

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis

(duration) ✓ yrs. ✓ mos. 3 ds.

CONTRIBUTORY (Secondary) ✓

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of July 19, 1930

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Rudolph J. Schaak, M. D.

, 19 (Address) Homan's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Andrew Rossdale	7-25-1930
20 UNDERTAKER	ADDRESS
E. P. & R. Lewis, 1439	Eden St

ec.—1-12-23—M&T—500 Bks.

E 59127

HEALTH DEPARTMENT—CITY OF BALTIMORE

194 E 59127

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Lemdale

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST 27-54 WARD)

2-FULL NAME Mrs. Sarah Leah Leon

(a) RESIDENCE NO. Belvedere & Greenspring WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 25 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Abe Leon

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

Informant: Charles Leon
(Address) 2143 Walbrook ave

Filed: 25 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24 1930

17 I HEREBY CERTIFY, That I attended deceased from July-21-1930, to July-27-1930, that I last saw h.. alive on July-24, 1930 and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
about 2 yrs
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Heat exhaustion
(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Seidel, M. D.

July 24 1930 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Hebrew Rest	July 25 1930
20 UNDERTAKER	ADDRESS
Jack Levin's	1739 E Baltimore

pec.—1-30—M. & T.—250 Bks

59128

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1930 E 59128.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2554 Francis ST. 13-59 (WARD)

2-FULL NAME Rudolph Koehler

(a) RESIDENCE No. W 4 Francis ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Koehler

DATE OF BIRTH (month, day, and year) May 8 1864

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	2	14 15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Henry Koehler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Frankenfeld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Christiana Koehler

(Address) 2554 Francis

JUL 25 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1930

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1930, to July 23, 1930.

that I last saw h[illegible] alive on July 21, 1930.

and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Heat exhaustion causing cessation of heart action

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? [illegible] Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Pirosh, M. D.

(Address) 220 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL July 25 1930

20 UNDERTAKER J. W. Pedersen Son

ADDRESS N. Y Pa

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59129 168 E 59129

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2809 Hamilton St. 27-43 Ward)

2-FULL NAME John L. Rezad

(a) RESIDENCE NO. 2809 Hamilton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Rezad

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Rezad

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Barbara Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant (Elizabeth Rezad)
(Address) 2809 Hamilton

15 [illegible] 25 1930 C. HAMPSON JONES, M. D.
[illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Hanging Rope

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of — —

Was there an autopsy? Yes

What [illegible] diagnosis? History

(Signed) [illegible], M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill — DATE OF BURIAL July 27 1930

20 UNDERTAKER Hurd Brack Son 1906 Edmondson — ADDRESS

Dr Wright 1015 S. Ellwood
Wolf 1688

...ec.—1-30—M. & T.—250 Blks.

E 59130 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 57 E 59130

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 723 S Ellwood Ave (St.) 1 (WARD)

2-FULL NAME Thomas Adam Magee

(a) RESIDENCE NO. 723 S Ellwood Ave St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Cora Magee

DATE OF BIRTH (month, day, and year) Dec 11, 1865

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	7	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Officer Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Salvation Army

BIRTHPLACE (city or town) (State or country) Ottawa Can

10 NAME OF FATHER Francis Magee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Catherine Richmond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

Informant Cora Magee

(Address) 723 S Ellwood Ave

C. THAMPSON JONES, M. D.

FILED JUL 25 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23. 1930

17 I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19..., that I last saw him alive on ....., 19..., and that death occurred, on the date stated above, at 1A m.

The CAUSE OF DEATH* was as follows:

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

7-25 1930 (Address) 1014 S Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 7/25 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Baltimore St

ec.—2-29-28—L. F. S.—500 Bks.

E 59131

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1292 E 59131

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE (No.) 913 N. 37 St ST. 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E Ryan

(a) RESIDENCE NO. 913 N. 37 St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) May 22-1872

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	2	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto Co
(State or country)

10 NAME OF FATHER Thomas Ryan

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Wright

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country)

Informant Miss Florence Ryan

(Address) 913 N. 37 St

Filed 5 1930 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24-30

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to July 24, 1930,

that I last saw her alive on July 23, 1930

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John J. Mooney, M. D.

7/24 1930 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL July 26 1930

UNDERTAKER A. S. Marshall ADDRESS 2539 Talbot Rd

...—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59132 90 E 59132

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.) 2549 McCulloh ST. 13-59 (WARD)

2—FULL NAME Charles Jones

(a) RESIDENCE NO. 2549 McCulloh ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

If married, widowed, or divorced
HUSBAND of (or) WIFE of Martina Jones

ATE OF BIRTH (month, day, and year) Aug 15, 1839

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	90	11	7	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

IRTHPLACE (city or town) (State or country) Md

0 NAME OF FATHER Unknown

1 BIRTHPLACE OF FATHER (city or town) (State or country) —

2 MAIDEN NAME OF MOTHER —

3 BIRTHPLACE OF MOTHER (city or town) (State or country) —

Informant Carrie Jackson

(Address) 2549 McCulloh St

Filed JUL 26 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22/30

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 22, 1930, that I last saw him alive on July 21, 1930 and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D M Beard M. D.

7/24 1930 (Address) 2029 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL 7/25 1930

20 UNDERTAKER Thomas E Kelson — ADDRESS 130 Presstman St

Cor.—10-10-29—A Co.—100 Bks.

David H. Corns.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59133

CERTIFICATE OF DEATH

51 ✓ E 59133

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 11 Way to Mercy Hospital St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David H Corns

(a) RESIDENCE NO. 3013 Hudson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Bertie L Corns.

6 DATE OF BIRTH (month, day, and year) May 31-1865

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
64	1	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER A. Corns

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Hester Bowles

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs. B. Corns
(Address) 3013 Hudson

15 1930 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 24. 30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. ds.

18 Where was disease contracted? —
If not at place of death?
Did an operation precede death? yes Date of Amputated
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) W. J. Corbus, M. D.
July 24 1930 (Address) 103 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cemetery	July 28 1930
20 UNDERTAKER George W Zirkler	ADDRESS 1737 Eager

sc.—1-30—M. & T.—250 Blks.

3 9/12
3 E 59134

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59134

CERTIFICATE OF DEATH.

x 31

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. ..... ST., 79 WARD)

2-FULL NAME Jerome Dolman

(a) RESIDENCE No. 506 Fairmount Ave. WARD Towson Md 2 days

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	married

If married, widowed, or divorced HUSBAND of or) ~~WIFE of~~ Nettie Dolman

DATE OF BIRTH (month, day, and year) 5/15/80

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	2	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md -

10 NAME OF FATHER Israel Hohman

11 BIRTHPLACE OF FATHER (city or town) Canada (State or country)

12 MAIDEN NAME OF MOTHER Anne Blackstone

13 BIRTHPLACE OF MOTHER (city or town) Md - (State or country)

Informant Johns Hopkins Hospital (Address)

Filed 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22-30

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to July 22, 1930, that I last saw h. ~~motive~~ alive on July 22, 1930, and that death occurred, on the date stated above, at 3 15 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis, appendicitis.

(duration) ..... yrs. ..... mos 5 da.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) 2 yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-20-22

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. H. Jones, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	July 25 30
20 UNDERTAKER Samuel F. Hensley	ADDRESS 58 Biddle

ec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59135

90 E 59135

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (NO. 1641 E. Eager ST. 113 WARD)

2-FULL NAME Gustav Adolph Kachele

(a) RESIDENCE NO. 1641 E Eager ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Barbara Kachele

DATE OF BIRTH (month, day, and year) Not Known

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	About 63			

OCCUPATION OF DECEASED Retired Musician

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Germany
(State or country)

10 NAME OF FATHER Paul Kachele

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

Informant Anna Barbara Kachele
(Address) 1641 E Eager St

Filed ..... 19 ..... Registrar

25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22-30

17 I HEREBY CERTIFY, That I attended deceased from 7-20 ..., 1930, to 7-22-30
that I last saw h... alive on 7-22, 1930
and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH was as follows:

Mitral Regurgitation
Chronic Nephritis
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Burgess, M.D.

7-23 1930 (Address) 500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Sat July 26 1930

20 UNDERTAKER Henry Storch Sons Inc.

ADDRESS 1301 E. Eager St

pec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59136

CERTIFICATE OF DEATH

73 ✓ E 59136

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 1745 Clarkson ST. 23-33 WARD)

2—FULL NAME Bernhine E. Krausz.

(a) RESIDENCE NO. 1745 Clarkson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 6 yrs. 7 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single.

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Dec 7 1923.

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6.	7.	14	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

IRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Harry Krausz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore.

12 MAIDEN NAME OF MOTHER Rose Gorenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD.

Informant Mr Harry Krausz.

(Address) 1745 Clarkson St.

Registered 5-1930 C. HAMILTON JONES, M. D. Registrar

BY .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24th 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to July 24, 1930, that I last saw h. ER alive on July 24, 1930 and that death occurred, on the date stated above, at 7:40 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Paralysis

Life (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) H. B. K. Campbell M. D.

7/24, 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	7/26/1930
20 UNDERTAKER John Howard & Son.	ADDRESS 90 Holliday

ec.—1-30—M. & T.—250 Bks

59137

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 59137

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals ST. 11-24 WARD)

ITY OF BALTIMORE: (NO. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Cox

(a) RESIDENCE NO. 931 N. Eutaw St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Cox

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65?			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John Restick

BIRTHPLACE (city or town) Harford Co.
(State or country) Md.

10 NAME OF FATHER Eli Cox

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Martha ?

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

Informant Records of
(Address) Balto. City Hosp.

5-1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23-30

17 I HEREBY CERTIFY, That I attended deceased from 7-3-30, 19..., to 7-23-30, 19..., that I last saw him alive on 7-23-30, 19..., and that death occurred, on the date stated above, at 9:25 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate.

(duration) ... yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Metastasis to spine & transverse Myelitis (duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

7-23, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. — DATE OF BURIAL July 26-30

20 UNDERTAKER Mrs. Lee H. Holland — ADDRESS 1918 N.

Cor.—10-10-29—A Co—100 Bks.

Wm Ernest Young.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59138 — 185 — E 59138

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 59138

1-PLACE OF DEATH

City of Baltimore: (No. 46. Aetmard St. St. 3-5 Ward)

2-FULL NAME Wm Ernest Young

(a) RESIDENCE NO. Aquasco md. St., Ward Aquasco Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (writs the word)
Male	Colrd	Marrd

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Ida Conway
(c) Name of employer Certain Messrs.

9 BIRTHPLACE (city or town)
(State or country) md.

PARENTS

10 NAME OF FATHER Jr. Young

11 BIRTHPLACE OF FATHER (city or town)
(State or country) md

12 MAIDEN NAME OF MOTHER Mary Rose Adams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) md

14 Informant S. Young. md
(Address)

Filed 2 5 1930 C. HARRISON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Fell
Struck Head from window
Concussion Brain.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

Jan. 26 1930 (Address) 1639 Brendon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Mary Cem Md.

DATE OF BURIAL 7/25 1930

20 UNDERTAKER Andrew J Brinsfield Aquasco Md.

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

E 59139

E 59139

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 16-N Ward)

2-FULL NAME Annie E. Jackson

(a) RESIDENCE NO. 1070 W Fairmount Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 10 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	54	2	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Jackson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Margaret Woodson
(Address) 1070 W Fairmount Ave

15 FILED JUL 25 1930 C. HARRISON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. Several days

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) H. H. Gordon, M. D.

July 23 (Address) Gordon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 25 1930
20 UNDERTAKER Mrs Katie R. Williams	ADDRESS 322 Schroeder St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59140

CERTIFICATE OF DEATH.

100-881

E 59140

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 947 Shaw St. 23-31 Ward)

2-FULL NAME Bernice Stanley

(a) RESIDENCE NO. 947 Shaw St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	col	Sing.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: L

6 DATE OF BIRTH (month, day, and year): 11/2/24

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	5	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): L

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Md

(State or country): L.

PARENTS

10 NAME OF FATHER: Chas. Stanley

11 BIRTHPLACE OF FATHER (city or town)

(State or country): S. C.

12 MAIDEN NAME OF MOTHER: Marie Miller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto Md

14 Informant: Marie Stanley

(Address): 947 Shaw St

Filed 7 5 1930, 19..... C. HARRISON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 7/24/30

17

I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 24, 1930, that I last saw h.. alive on July, 1930, and that death occurred, on the date stated above, at 9.05 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) ....yrs. ....mos. 14 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? L Date of L

Was there an autopsy? no

What test confirmed diagnosis? L

(Signed) D Harrell, M. D.

7/26 1930 (Address) 830 Shaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cemetery — Date of Burial: July 26, 1930

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 322 Schroeder St

...c.—1-30—M. & T.—250 Blks.

E 59141

HEALTH DEPARTMENT—CITY OF BALTIMORE

Mary Dolores Vickers

CERTIFICATE OF DEATH.

E 59141

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH South Baltimore General Hospital
ITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

2-FULL NAME Baby girl Vickers

(a) RESIDENCE NO. 716 Belgian Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of —

DATE OF BIRTH (month, day, and year) July 12 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer .....

BIRTHPLACE (city or town) Balto Md
(State or country)

10 NAME OF FATHER William Vickers.

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Mitchell Banks

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

Informant Mrs Mrs Vickers
(Address) 716 Belgian Ave

Filed JUL 25 1930 19 ..... JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/25/30

17 I HEREBY CERTIFY, That I attended deceased from 7-12, 1930, to 7/25, 1930, that I last saw h... alive on 7/25, 1930, and that death occurred, on the date stated above, at 8.15a. m.

The CAUSE OF DEATH* was as follows:

Premature Infant

(duration) ..... yrs. ..... mos 12 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Physical Signs

(Signed) Joseph Lanzkaitis M. D.

(Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 25th 1930
20 UNDERTAKER Henry Hoech Sons Inc.	ADDRESS 1301 E Eager

ec.—1-30—M. & T.—250 Blks.

E 59142 HEALTH DEPARTMENT—CITY OF BALTIMORE 51 E 59142

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.) 124 E Clement ST. 14-23 WARD

2-FULL NAME Joseph Bork.

(a) RESIDENCE NO. 124 E Clement ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed or divorced HUSBAND of (or) WIFE of Theresa V. Bork.

DATE OF BIRTH (month, day, and year) Aug 26 1866

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
63	10	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer in S

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant (Address) Theresa V. Bork. 124 E Clement St

FILED 7 25 1930 19 THOMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from January 5 1930 to July 23 1930, that I last saw him alive on July 23 1930, and that death occurred, on the date stated above, at 5 32 A m.

The CAUSE OF DEATH* was as follows: Easter Standstill Time.

Diabetes Mellitus, Mitral Regurgitation, Cerebral Thrombosis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What tests confirmed diagnosis? Physical Exam & Laboratory Exam

(Signed) J. Edward Morris M. D.

7-23 1930 (Address) 107 East West

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A & C Co — DATE OF BURIAL 7-26 1930

20 UNDERTAKER E & B Harle 1156 & 1208 St. — ADDRESS

ec.—1-30—M. & T.—250 Blks

E 59143 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59143

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (NO. ST. 3-5 WARD)

2-FULL NAME Thomas Barley

(a) RESIDENCE NO. 1118 E. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1858

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Thomas Barley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Hannah Burr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Records of (Address) Balto. City Hosp.

Filed 7-24 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22-30

17 I HEREBY CERTIFY, That I attended deceased from 12-14-26, 19..., to 7-22-30, 19...,

that I last saw him alive on 7-22-30, 19...,

and that death occurred, on the date stated above, at 10:10 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) 3½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) infusion yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett, M. D.

7-24, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

UNDERTAKER Commissioner of Health.

ADDRESS JUL 25 1930

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59144 1944 E 59144

E 59144

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St. 6-11 Ward)

2-FULL NAME Henry Wischhusen

(a) RESIDENCE NO. 1127 N. Linwood St., 6 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V. —

6 DATE OF BIRTH (month, day, and year) Aug 20 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
35 36		11	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odell
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Henry Wischhusen

11 BIRTHPLACE OF FATHER (city or town) (Germany)
(State or country)

12 MAIDEN NAME OF MOTHER Emma Ofner

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mary V. Wischhusen
(Address) 4017 Austin Ave

15 Filed 26 1930 Hampson [illegible] M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22-30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and (from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia (Contd Cerebral Hemorrhage Contd 2 days)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension —

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Lilly, M. D.

July 24 1930 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	July 26 1930
20 UNDERTAKER Lilly & Sons Inc	ADDRESS 4038 Wash Blvd

...c.—1-30—M. & T.—350 Blks.

E 59145 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59145

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary

ITY OF BALTIMORE: (No. Ivory and Fairmount ST., 7th WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Plitt

(a) RESIDENCE No. 2004 Bank St ST., 2 WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Oct. 29th 1886

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
44	43	8	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Foundry Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto. Md.
(State or country)

10 NAME OF FATHER Antone Plitt

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Julia Solil.

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

Informant Julia Plitt (Mother)
(Address) 2004 Bank St.

Filed 2-5 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July xx-1930

17 I HEREBY CERTIFY, That I attended deceased from February, 1930, to July 22, 1930, that I last saw him alive on ....., 19....., and that death occurred, on the date stated above, at 7:40 P m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Right Inguinal Glands generalized

(duration) ...yrs. ...mos ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? February 1930

Did an operation precede death? No Date of June 1930

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) James L. Deering, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery — DATE OF BURIAL July 25th 1930

20 UNDERTAKER Lilly & Sisco — ADDRESS 400 E. Monument

ec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59146

CERTIFICATE OF DEATH.

31 E 59146

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 1400N Lakewood Ave ST. 8-16 WARD)

2-FULL NAME Anna C. Dumps

(a) RESIDENCE NO. 1400 N Lake wood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Nov 28' 1906.

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	7	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy wrapper

(b) General nature of industry, business, or establishment in which employed (or employer) Dockman's candy co

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Austria

10 NAME OF FATHER Frank Dumps

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Anna Sell ner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

Informant Frank Dumps

(Address) 1400 N Lakewood Ave.

Filed 7-5 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1930

17 I HEREBY CERTIFY, That I attended deceased from

July 21, 1929, to July 23, 1930,

that I last saw h alive on July 23, 1930,

and that death occurred, on the date stated above, at 5* 55 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) Thos J. Sessums, M. D.

7/25/30 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy redeemer cemetery

DATE OF BURIAL July 26 1930

ADDRESS

20 UNDERTAKER

Lilly & Zeiler Inc.

403 S. Wolfe

Cor.—10-10-29—A Co.—100 Bks.

Walter H Bell

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59147

74-01

E 59147

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1139 Ward St. 7-29 Ward)

2-FULL NAME Walter H Bell

(a) RESIDENCE NO. 1139 Ward St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	62	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shipping clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Ship
(r) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Josh Bell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Ann Jane Ballient

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mary E. Rench
(Address) 3241 W. Woodbine

Filed 25 1930 C. HARRISON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

a Coronary Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles H Bowles M. D.

July 25. 1930 (Address) 3601 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 7/26/30

20 UNDERTAKER A. Jones III

ADDRESS 1 Eden

c.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59148

CERTIFICATE OF DEATH

67-092 E 59148

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 2211 E. North Ave ST. 8-16 WARD)

2—FULL NAME John Edward Gunter

(a) RESIDENCE NO. 2211 E North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

f married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Bertha L. Gunter

ATE OF BIRTH (month, day, and year): April 30 1877

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	2	23	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Richlorite of Mercury Mfgr

(b) General nature of industry, business, or establishment in which employed (or employer): Mfg Chemists

(c) Name of employer: Sharp & Dohme

RTHPLACE (city or town) State or country): Balto

0 NAME OF FATHER: Herman Gunter

1 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

2 MAIDEN NAME OF MOTHER: Bertha Schmidt

3 BIRTHPLACE OF MOTHER (city or town) (State or country): Atlantic Ocean on way to U.S.A.

Informant: Bertha L. Gunter

(Address): 2211 E North Ave

Filed 5 1930 19 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 30

17 I HEREBY CERTIFY, That I attended deceased from July 7 19 29 to July 23 19 30

that I last saw him alive on July 22 19 30

and that death occurred, on the date stated above, at 7 15 A m. EST

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

Pulmonary Oedema

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Bichloride & Cyanide of Mercury Poisoning

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Broad Aleock M. D.

7/23 1930 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	July 26 1930
20 UNDERTAKER: Robt J Turner	ADDRESS: 1402 N. Broadway

...ec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59149 90 E 59149

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 76-37 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Robinson

(a) RESIDENCE NO. ? ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 ?			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records of

(Address) Balto. City Hosp.

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22-30

17

I HEREBY CERTIFY, That I attended deceased from 1-18-13, 19..., to 7-22-30, 19..., that I last saw him alive on 7-22-30, 19..., and that death occurred, on the date stated above, at 4:30 A.m.

The CAUSE OF DEATH* was as follows:

Myocoraditis, chronic and acute.

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 17 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1. Hospital 2. Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical exam.

(Signed) Paul Padget, M. D.

7-25, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilmington N.C.	July 26 19 3
20 UNDERTAKER	ADDRESS
Joseph A. Lochte & Son	Mount

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59150

CERTIFICATE OF DEATH

88 E 59150

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. En route to University, 18 Fremont St.

2-FULL NAME John Calhoun

(a) RESIDENCE NO. 1103 Vine St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Bertha Calhoun

6 DATE OF BIRTH (month, day, and year) Aug 16 - 1894

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35	11	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Mo.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Bertha Calhoun
(Address) 657 W Baltimore St

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

Ret

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D.

7-24-1930 (Address) 729 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	July 27 1930
20 UNDERTAKER	ADDRESS
Joseph A Swirsky	4099 Fremont

Spec. 6-9-19—H. P. Co.—1000 Blks.

E 59151 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59151

CERTIFICATE OF DEATH.

REGISTERED NO. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1640 Jackson (St.) 24-34 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L. Gurry.

(a) RESIDENCE. NO. 1640 Jackson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 14th 1929

7 AGE — Years: 10 — Months: — Days: 10 — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER: James L. Gurry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Nellie J. Brambitta

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: James L. Gurry
(Address) 1640 Jackson St

15 Filed MAY 5 1930 . By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1930

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1930, to July 24, 1930, that I last saw him alive on July 24, 1930, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary): Convulsions

(duration) yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) R. L. Campbell M. D.

7/25, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westlern Cemetery — DATE OF BURIAL: July 26 1930

20 UNDERTAKER: E. Schloman & Son — ADDRESS 1039 Hanover St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59152

CERTIFICATE OF DEATH

117

E 59152

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St Joseph Hospital (St.) 16 (Ward)

2-FULL NAME Margaret M. Connor

(a) RESIDENCE NO. 1945 N Collington Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19 1920

7 AGE	Years	Months 10	Days 6	IF LESS than 1 day ....hrs. or ....min.
	9			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Springfield Mass

PARENTS

10 NAME OF FATHER Alexander P Connor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Eugenia Gallenne

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New Orleans

14 Informant Alexander Connor
(Address) 1945 N Collingtonave

15 Filed ..... 19.... C. HARRISON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptur A Aneurism

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of July 25/30
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) A C Elliott, M. D.
19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL 6/26 1930

20 UNDERTAKER Leo J Cook.

ADDRESS 1723 Patterson Pk ave

E 59153

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11 E 59153

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Josephs Hos St. 20-10 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John R. Carrickson

(Residence in Baltimore: No. 217 N. Monastery Ave St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word) Single

6-DATE OF BIRTH. Feb. (Month) 16 (Day) 1924 (Year)

7-AGE. 6 yrs. 5 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS:

10-NAME OF FATHER. Rev. Wm. M. Carrickson

11-BIRTHPLACE OF FATHER. (State or Country). City

12-MAIDEN NAME OF MOTHER. L. Ruth Kennedy

13-BIRTHPLACE OF MOTHER. (State or Country). City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. Wm. M. Carrickson

(Address) 217 N. Monastery Ave

15- Buried 1939 C. HAMPSON JONES, M. D. 192 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 24 (Day) 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of Appendix

Operation July 6

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) mos. 1 ds.

(Signed) J. J. C. Gladden M. D.

(Coroner.)

192 (Address) 143 N. Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Lorraine Cem DATE OF BURIAL. July 26 1930

20-UNDERTAKER. Wm J Tickner & Sons ADDRESS N. Y. Pa.

ec.—1-30—M. & T.—250 Blks

E 59154 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59154

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 Augusta ST. 20-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Mrs~~ Catherine Josephine Kraft

(a) RESIDENCE NO. 220 Augusta ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Nov 23 1864

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	8		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Henry Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Walper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Henry Kraft

(Address) 220 Augusta

Filed JUL 25 1930 19 C. HAMPSON JONES, M.D. Registrar

For ARR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23-1930

17 I HEREBY CERTIFY, That I attended deceased from May 2 - 1930, to July 23, 1930,

that I last saw her alive on July 23, 1930,

and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

Arterial Hypertension.

(duration) yrs. 4-6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) D. Lloyd Johnson, M. D.

19 (Address) 4200 Frederick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 7-26 1930

20 UNDERTAKER Wm. J. Sudbrink Inc

ADDRESS 4.68 a m

c.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59155 90 E 59155

CERTIFICATE OF DEATH

1—PLACE OF DEATH Maryland General Hosp. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 634 ST., WARD)

2—FULL NAME Sarah Elizabeth Reed

(a) RESIDENCE NO. 1800 N. Calvert ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

ATE OF BIRTH (month, day, and year) Oct? 1860

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	69	9	—	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Balto. County
(State or country) Md.

0 NAME OF FATHER Wm. Edward Reed

1 BIRTHPLACE OF FATHER (city or town)
(State or country) Boston Mass

2 MAIDEN NAME OF MOTHER Sarah Elizabeth Thomas

3 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. County Md.

Informant Hospital records.
(Address)

Filed 5 1930, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from 6-30, 1930, to July 25 1930, that I last saw her alive on July 25, 1930 and that death occurred, on the date stated above, at 12:45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

[illegible]

[illegible]

exact [illegible] (duration) (many years) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension, Chronic

myocarditis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. + lab. tests

(Signed) Robert V. Chenowith, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 28 1930
20 UNDERTAKER	ADDRESS
H. S. Tucker & Son	North & Penn Ave

Cor.—10-10-29—A Co.—100 Blks.

E 59156

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 | E 59156

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 28 S. Spring St. 3-4 Ward)

2-FULL NAME Lewis Gaines

(a) RESIDENCE NO. 28 S Spring St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residrnce in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Mal	Colrd	widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ~~Mal~~ Matilda Gaines

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	74			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Annapolis

PARENTS

10 NAME OF FATHER Lewis Gaines

11 BIRTHPLACE OF FATHER (city or town)
(State or country) ~~Scotland~~ Annapolis

12 MAIDEN NAME OF MOTHER Matilda Myers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Frederick Md

14 Informant Mollie Hurd
(Address) 28 S Spring

Filed 19 C. HAMPSON JONES Registrar.

25 1930 Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

About (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 28 S Spring

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Benton, M. D.

7/23/30 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	7/26/1930
20 UNDERTAKER	ADDRESS
George A Diehl Sons	1733 Harford

ec.—1-30—M. & T.—250 Bks.

E 59157 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59157

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1113 N. Wolfe ST. 8-13 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Wilson

(a) RESIDENCE NO. 1113 N. Wolfe st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Single.

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 13, 1916

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	7	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Va.
(State or country)

10 NAME OF FATHER Robert Wilson

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Esther Bell

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

Informant Esther Pride

(Address) 1113 N. Wolfe st.

Filed ....., 19 .... By C. HAMPSON JONES, M.D.
5-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-25-30

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to July 25, 1930,

that I last saw h.e. alive on July 25, 1930,

and that death occurred, on the date stated above at 4:35 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum & Aur.

(Signed) Wm. C. Longbeeee, M. D.

, 19 (Address) 1420 E. Chase.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenlawn	July 27, 1930
UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1715 Eastern Ave

Dec.—1-30—M. & T.—250 Blks.

E 59158 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59158

91-002

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Saint Francis Convent ST., 16th WARD)

2-FULL NAME Sister Mary Centuary Braxton

(a) RESIDENCE NO. Chas. & Brentwood Sts. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) December 1852

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sister 065

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) Va.
(State or country)

10 NAME OF FATHER Daniel Braxton

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Scott

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

Informant Rev. Mother Superior
(Address) Chas. & Brentwood Sts.

Filed ..... 19 ..... Registrar C. HAMPSON JONES, M.D.

T1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/25/30

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1930, to July 25, 1930, that I last saw her alive on July 24, 1930, and that death occurred, on the date stated above, at 12.20 p.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) about yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Present symptoms

(Signed) Mary F. Deagle M.D.

7/25 1930 (Address) 1028 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL July 26, 1930

UNDERTAKER Mrs. R.G. Elliott

ADDRESS 1725 Eastern Ave

Catherine Killalea ✓

E 59159

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59159

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 Mosher ST. 14-20 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Killalea

(a) RESIDENCE NO. 124 Mosher ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of .....

DATE OF BIRTH (month, day, and year) April 1866

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	3		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Matron 086

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer City Hospital

BIRTHPLACE (city or town) (State or country) Baltimore County

10 NAME OF FATHER Thomas Killalea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Barron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mary E. Scanlon

(Address) 228 W. Madison St

C. HAMPSON JONES, M. D.

5 1930 , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1930

17

I HEREBY CERTIFY, That I attended deceased from June 26, 1930, to July 24, 1930.

that I last saw h alive on July 23, 1930,

and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Ceberal Hemorrhage

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? —

(Signed) Edw. J. Cunningham M. D.

, 19 (Address) 24 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL July 26 1930

20 UNDERTAKER Harry H. Fritzke — ADDRESS 4401 Edmondson

pec.—1-30—M. & T.—250 Blks

(Neilson)

E 59160

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59160

CERTIFICATE OF DEATH.

100-00

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (NO. ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Neilson

(a) RESIDENCE NO. 808 N Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) May 13 1860

AGE	Years	Months 2	Days 10	If LESS than 1 day, hrs. or min.
	70			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balt Md.

10 NAME OF FATHER Frank Broesler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

Informant Next Friends.

(Address)

Filed 5-1930, 19 H. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23-30

17 I HEREBY CERTIFY, That I attended deceased from 7-3, 1930, to 7-23, 1930, that I last saw h[illegible] alive on 7-23, 1930, and that death occurred, on the date stated above, at 8 35 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Lupo, M. D.

7/23, 1930 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: July 26 1930

UNDERTAKER: William G. Schaeffer — ADDRESS: 1816 Monument

Spec. 1-30 M. & T.—250 Blks.

E 59161

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59161

CERTIFICATE OF DEATH.

44

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 1130 W Saratoga ST. 18th WARD)

2-FULL NAME Neal Spano

(a) RESIDENCE NO. 1130 W Saratoga ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) 1875

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
55	—	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horseman 02

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

BIRTHPLACE (city or town) St Marys Co.
(State or country) Maryland.

10 NAME OF FATHER Henry Spano

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Lee

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Maryland

Informant Mrs Rosa Spano
(Address) Baltimore City Hosp

Filed 5-1930, 19 ... C. HAMPSON JONES, M.D. Registrar
By RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23-30

17 I HEREBY CERTIFY, That I attended deceased from 7-7-, 1930, to 7-23, 1930, that I last saw him alive on 7-23-, 1930, and that death occurred, on the date stated above, at 1.50 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pylorus
with local metastasis.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.
(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Intermittent

Did an operation precede death? yes Date of 7-18-30

Was there an autopsy? yes

What test confirmed diagnosis? X-ray & autopsy

(Signed) Fred M. Underwood, M.D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pet[illegible]

DATE OF BURIAL 7-26 1930

20 UNDERTAKER David Easton

ADDRESS 916 E Pratt

Sec.—1-30—M. & T.—250 Blks

E 59162

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59162

CERTIFICATE OF DEATH.

129

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 655 W. Mulberry st (WARD) 4-25

2-FULL NAME James King

(a) RESIDENCE NO. 655 W. Mulberry st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5th. 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Greenville, N.C.

10 NAME OF FATHER Balam King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greenville, N.C.

12 MAIDEN NAME OF MOTHER Addie Best.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greenville, N.C.

Informant Mrs Clora Watkins (Sister)

(Address) 655 W. Mulberry st

Filed ..... 19 ..... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25th. '30

17 I HEREBY CERTIFY, That I attended deceased from July 22nd 19 30, to July 25th, 19 30

that I last saw him alive on July 25th, 19 30

and that death occurred, on the date stated above, at 2.00 a.m.

The CAUSE OF DEATH* was as follows:

Acct. Parenchamatus Nephritis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Unknown Uremia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklin st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 7-26 1930

20 UNDERTAKER: Dan Tenton

ADDRESS: Balto

Dec.—1-30—M. & T.—250 Blks.

E 59163 HEALTH DEPARTMENT—CITY OF BALTIMORE 74 of E 59163

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5614 Benton Heights ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lozetta Mc Graw

(a) RESIDENCE NO. 5614 Benton Heights ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of Peter Mc Graw

DATE OF BIRTH (month, day, and year) Oct 5 1853

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	76	9	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (City or town) (State or country) Germany

10 NAME OF FATHER Dennis Kirow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorit Thurow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Michael O. Rooks

(Address) 5614 Benton Heights

Filed JUL 25 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24-1930

17 I HEREBY CERTIFY, That I attended deceased from July 20 1930, to July 24 1930

that I last saw her alive on July 24, 1930,

and that death occurred, on the date stated above, at 2315 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhages (Cerebral Hemorrhage)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clark Smith, M. D.

1930 (Address) 4702 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 7/28 1930

UNDERTAKER William Cook

ADDRESS 1217 St Paul

oc.—8-16-29—L. F. S.—100 Bks.

Dr Dram ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59164

E 59164

CERTIFICATE OF DEATH

24-001

REGISTERED NO. 2129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1170 Montecoke ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Karl F Stockhouse

(a) RESIDENCE NO. 1170 Montecoke ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Stockhouse

DATE OF BIRTH (month, day, and year): Sept 15, 1862

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	10	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer, Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 940

(c) Name of employer: Swindells

BIRTHPLACE (city or town) (State or country): Germany

10 NAME OF FATHER: Frederick Stockhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Barbara Stockhouse

(Address) 1170 Montecoke St

Filed 1930 By C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1928, to July 25, 1930

that I last saw h[illegible] alive on July 25 1930

and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Uremia Poisoning

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard Dram, M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

20 UNDERTAKER: Wm Cook

DATE OF BURIAL: 7/28 1930

ADDRESS: 1219 E Cold St

...ec.—2-29-28—L. F. S.—500 Bks.

E 59165

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59165

CERTIFICATE OF DEATH

179-001

REGISTERED NO. ...

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. Woman's Hospital ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ann Lisa Norris

(a) RESIDENCE NO. 1205 John ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

...ngth of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

...EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

...ATE OF BIRTH (month, day, and year) Aug. 9, 1923

...GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6	11	16	

...CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

...IRTHPLACE (city or town) Baltimore (State or country) Maryland.

10 NAME OF FATHER Walter A. Norris

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Helen Brown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

Informant Mrs Helen Norris

(Address) 1205 Johns.

...ed 5 1930, 19 H. ...ARSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1930, to July 25, 1930

that I last saw her alive on July 25, 1930

and that death occurred, on the date stated above, at 8 30 a.m. (D. L. S. T.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Extensive 2nd degree burns (duration) yrs. mos. 22 ds.

Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Rudolph J. Schork, M. D.

(Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 7/28 1930

20 UNDERTAKER Chas. P. Ward & Son

ADDRESS 1180 W. Mt. Royal Ave.

ec.—1-30—M. & T.—250 Bks.

E 59166 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59166

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) #7 York Court ST. 12-46 (WARD)

2-FULL NAME Andrew Muncks

(a) RESIDENCE NO. #7 York Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Viola Muncks

DATE OF BIRTH (month, day, and year) Dec 12 1864

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	7	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bank Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Union Trust Co.

BIRTHPLACE (city or town) Baltimore

(State or country) Md.

10 NAME OF FATHER Conl Muncks

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Lana

13 BIRTHPLACE OF MOTHER (city or town) Boston

(State or country) Mass.

Informant Mrs Viola Muncks

(Address) 7 York Court

1930 19 Mar C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to July 24, 1930.

that I last saw him alive on July 24, 1930.

and that death occurred, on the date stated above, at 7.45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung.

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. A. Hochman, M. D.

19 (Address) 6535 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 7/26/1930

20 UNDERTAKER Frank E. Burger — ADDRESS 363 X Falls Road

ec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59167

E 59167

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: NO. 1219 W Lanvale 6-23 WARD

2-FULL NAME Mrs Celia Bailey

(a) RESIDENCE NO. 1219 W Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX F | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Wd

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 72			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Almshouse Court House Md

10 NAME OF FATHER Chas Mt. Meade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Almshouse Court House Md

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Virginia Bailey

(Address) 1219 W Lanvale St

C. HAMPSON JONES, M. D. Registrar

5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24/30

17 I HEREBY CERTIFY, That I attended deceased from 1904, 19..., to 1930, 19..., that I last saw h... alive on 7/24/30 and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DE... was as follows: C. Myocarditis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas A Tyner M. D.

, 19 (Address) 1400 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 7-27 1930

20 UNDERTAKER Mrs Chas H. Bailey

ADDRESS 1421 Jefferson St

...ec.—1-30—M. & T.—250 Bks

E 59168 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59168

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3409 Cedardale Rd. (WARD) 45-62

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah L. Berry

(a) RESIDENCE No. 3400 Cedardale Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

If married, widowed, ~~or divorced~~
~~HUSBAND of~~
(or) WIFE of Frank Berry

DATE OF BIRTH (month, day, and year) 1850

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Washington D. C.

10 NAME OF FATHER Jackson Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Leonard J. Luttehagen
(Address) 3400 Edgadale Rd

C. HAMPSON JONES, M. D.
Registrar

Filed ... 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to July 24, 1930.

that I last saw her alive on July 23, 1930.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Angina Pectoris.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Senility, Arteriosclerosis.

(duration) 10 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Queen, M. D.

7/25 1930 (Address) 3501 Garrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	7/26 1930
20 UNDERTAKER J. J. Inman	ADDRESS 3009 E. Baltimore

Rec.—2-29-28—L. F. S.—500 Bks.

E 59169

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59169

CERTIFICATE OF DEATH

74-901

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1800 Light ST., 23-32 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barbara Eagle

(a) RESIDENCE NO. 1800 Light ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
W.	W	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of George Eagle

DATE OF BIRTH (month, day, and year) 1847

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	-	-	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

Informant Anna Eagle

(Address) 1800 Light St

FILED 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23-1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to July 23, 1930.

That I last saw her alive on July 23, 1930.

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What (est confirmed diagnosis)? Clinically

(Signed) R. K. Campbell M. D.

7/24, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edgewood

DATE OF BURIAL 7/26 1930

20 UNDERTAKER J. P. Riley Home

ADDRESS 1518 Eden St

ec.—1-12-23—M&T—500 Bks.

James A. P. Bortell ✓ 100-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59170 E 59170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Jenkins Memorial Hospital REGISTERED NO. 25-17

CITY OF BALTIMORE: (No.) 1000 Caton Ave ST., WARD (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. P. Bortell

(a) RESIDENCE NO. Granite, Md. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Maude Bortell

DATE OF BIRTH (month, day, and year) — — 1872

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58 yrs.			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 03

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Howard Co. Md.

10 NAME OF FATHER Caleb H. Bortell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bridget Looby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant (Address) Jenkins Memorial Hosp. 1000 Caton Ave.

F 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24/30 19

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 19 28, to July 24, 19 30,

that I last saw him alive on July 24, 19 30,

and that death occurred, on the date stated above, at 11.05 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary congestion & Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Paralysis G.S. Years

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) W. F. Bird, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodstock Md DATE OF BURIAL 7/26 1930

A UNDERTAKER J. J. Dalton & Son ADDRESS 1818 Eight St

1-30—M. & T.—250 Blks

E 59171 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59171

CERTIFICATE OF DEATH.

+114

1-PLACE OF DEATH Mercy Hospital. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (NO. ST. 4-7 WARD)

2-FULL NAME Edward Carter

(a) RESIDENCE NO. 12 Chenoah Ave ST., WARD Fulton Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	white	single

If married, widowed, or divorced HUSBAND of (or) WIFE of Mch. 19, 1926

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
4	4	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto Md.
(State or country)

10 NAME OF FATHER Francis Carter

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Darragh

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

Informant Husband Friends

(Address) Edmondson Hghts. Md

Registrar

6 1930 S.NOF NO.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-25-30

17 I HEREBY CERTIFY, That I attended deceased from 7-24, 1930, to 7-25, 1930, that I last saw him alive on 7-25, 1930, and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Acute Infectious Disease (eye)

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L Leyko, M. D.

7/25, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL July 26/30

UNDERTAKER Harry A. Deitzler 4101

ADDRESS Edmondson

...—2-29-28—L. F. S.—500 Blks.

E 59172

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47

E 59172

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1045 Brantly Ave 16-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sadie Taylor

(a) RESIDENCE NO. 1045 Brantly Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: James Taylor

DATE OF BIRTH (month, day, and year): [illegible] 1878

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	52			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto. Md

10 NAME OF FATHER: James Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Herman Tolbert

(Address) 1045 Brantly Ave

C. HAMPSON JONES, M. D.

Registrar

Filed 6 1930 19 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23-'30

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to July 23, 1930, that I last saw h[illegible] alive on July 23, 1930 and that death occurred, on the date stated above, at 4 40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. E. McCard M. D.

7/24 1930 (Address) 2029 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: July 27 1930

20 UNDERTAKER: John H. Toadvine

ADDRESS 1027 Druid Hill

rec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59173

E 59173

CERTIFICATE OF DEATH.

REGISTERED NO. 16-623

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged men + women's ST. Home WARD)

2-FULL NAME Lucy Powell

(a) RESIDENCE NO. 822 N. Carrollton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1867

AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	63			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

Informant Ida Taylor

(Address) 804 N. Fremont Ave

1930 C. HAMPSON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24-1930

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to July 24, 1930, that I last saw h alive on July 24, 1930 and that death occurred, on the date stated above, at 10.2 a. m.

The CAUSE OF DEATH* was as follows:

Acute Dysentery

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Wheatley, M. D.

July 27, 1930 (Address) 1200 Druid Park Dr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL July 26, 30

20 UNDERTAKER Jos. H. Broadus ADDRESS 1027 Druid Hill

C.—1-30—M. & T.—250 Bks.

E 59174 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 E 59174

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1018 Lor ST. 5-8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Sanders

(a) RESIDENCE NO. 1018 Lor St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	M

If married, widowed, or divorced HUSBAND of (or) WIFE of Susie Sanders

6 DATE OF BIRTH (month, day, and year) 1897

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
33			

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Balto Md

9 NAME OF FATHER Charles Sanders

10 BIRTHPLACE OF FATHER (city or town) (State or country) Md

11 MAIDEN NAME OF MOTHER Martha Mollows

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Irene Truell

(Address) 1018 Lor St

Filed 6-1930, 19 C. HAMPSON JONES, M. D. Registrar By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1930

17 I HEREBY CERTIFY, That I attended deceased from March, 1930, to July 23, 1930, that I last saw h[illegible] alive on July 22, 1930, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Aortic Aneurysm (ascending arch)

(duration) yrs. 5 mos da.

CONTRIBUTORY (Secondary) Generalized Anasarca

(duration) yrs. 5 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. F. Young, M. D.

7/24, 1930 (Address) 1424 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary crm

DATE OF BURIAL 7-26 1930

UNDERTAKER Byron Wright 1218 Mc Elderry St

ADDRESS

ec. 2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59175

CERTIFICATE OF DEATH

129 ✓ E 59175

REGISTERED NO. 24-35

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 1434 Towson St (STREET) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Thomas

(a) RESIDENCE NO. 1434 Towson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Charles W. Thomas.

6 DATE OF BIRTH (month, day, and year) Jan. 17. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

10 NAME OF FATHER George Henry.

11 BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

Informant Catherine Hirschfeld Hampson

(Address) 1434 Towson

C. HAMPSON JONES, M. D.
Registrar

JUL 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23-1930

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1923 to July 23 1930

that I last saw her alive on July 22 1930

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Hypertentori, arteria Sclerosis

Chronic Interstitial Nephritis

Uraemia 4 days. (Cerebral Hemorrhage)

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. 22 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Uraemia

(Signed) Thos. F. Stevens, M. D.

7/28/1930 (Address) 2078 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem

DATE OF BURIAL July 26 1930

UNDERTAKER Charles A. Stevens

ADDRESS 2078 Harford Ave

Spec.—1-10-21—M&T—1500 Blks.

E 59176

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59176

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1309 W. Saratoga - (St.) 14-7th (WARD)

2-FULL NAME Mary Wirtz

(a) RESIDENCE NO. 1309 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married -

6a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Edward Wirtz

6 DATE OF BIRTH (month, day, and year): ?? 1867

7 AGE — Years: 63 — Months: ? — Days: ? — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work -

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Russia - Germany

PARENTS

10 NAME OF FATHER: John Krieger.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany -

12 MAIDEN NAME OF MOTHER: Susanna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mr. Edw. Wirtz 1309 W. Saratoga -

15 6 1930 G. HAMPSON JONES, M. D. Registrar

DEPUTY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25 1930

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1930, to July 25, 1930,

that I last saw her alive on July 24, 1930,

and that death occurred, on the date stated above, at 12:15 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency —

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no — Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) A. V. Buchauer -, M. D.

7/25, 1930 (Address) 37 S. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 7-28-30

20 UNDERTAKER: Mrs. M. S. Fink

ADDRESS: 2112 Wilkens Ave

ec.—1-30—M. & T.—250 Bks

E 59177 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59177

E 59177

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 1609 Eastern Ave ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Ratajczak

(a) RESIDENCE NO. 1609 Eastern ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Helen Ratajczak

DATE OF BIRTH (month, day, and year) 1880

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Jos. W. Lux (Address) 1609 Eastern Ave

C. HAMPSON JONES, M. D. Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1930, to July 24, 1930, that I last saw h[im] alive on July 24, 1930, and that death occurred, on the date stated above, at 10.10 a. m.

The CAUSE OF DEATH* was as follows: Coronary

Thrombosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Odema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Tumor

(Signed) Joseph Sendler, M. D.

, 19 (Address) 310 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem

DATE OF BURIAL July 28 1930

20 UNDERTAKER Wm Fialkowski

ADDRESS 1618 Eastern ave

...ec.—8-16-29—L. F. S.—100 Bks.

E 59178

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 59178

REGISTERED NO.

1—PLACE OF DEATH

...ITY OF BALTIMORE: (No. 509 N. Schroeder St. ST 18-26 ...RD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth A. Russell,

(a) RESIDENCE NO. 509 N. Schroeder St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

...ngth of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

...EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
...male	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Russell,

...ATE OF BIRTH (month, day, and year) Dec. 23. 1842

...GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	87	7	2	

...CCUPATION OF DECEASED

(a) Trade, profession or ...particular kind of work None

(b) General nature of industry, ...business, or establishment in ...which employed (or employer)

...(c) Name of employer

...IRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER John L. Wain,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Katherine Kraus,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

Informant Miss Kathryn M. Russell

(Address) 509 N. Schroeder St

Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

...1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUL 25 1930

17 I HEREBY CERTIFY, That I attended deceased from January 30, 1930, to July 25, 1930, that I last saw h... alive on July 25, 1930 and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arterio-sclerosis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Pneumonia.

(Signed) Herbert F. Steelman, M. D.

, 19 (Address) 6 East Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL JUL 28, 1930

20 UNDERTAKER Geo. W. Sisk

ADDRESS 2706 EDMONDSON Ave.

ec.—1-12-23—M&T—500 Pks.

Chenoweth

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59179

CERTIFICATE OF DEATH.

1611 E 59179

1668

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2755 W. Mosher ST., WARD)

2-FULL NAME Baby boy Chenoweth

(a) RESIDENCE NO. 2755 W. Mosher ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 if yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Boy	White	S

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) July 25, 1930.

AGE	Years	Months	Days	If LESS than 1 day, ..6.. hrs. or ..... min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore Md.
(State or country)

10 NAME OF FATHER John Chenoweth

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie Deitz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

Informant John Chenoweth
(Address) 2755 W. Mosher St.

1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 19 30

17 I HEREBY CERTIFY, That I attended deceased from July 25 , 1930 , to July 25 , 1930.

that I last saw h alive on July 25 , 1930,

and that death occurred, on the date stated above, at 10.00 m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Edw Hendelman, M. D.

7/26/30 (Address) 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	July 26 1930
20 UNDERTAKER	ADDRESS
George L. Lehnert	326 Fulton Ave.

c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59180

CERTIFICATE OF DEATH

185 VE 59180

REGISTERED NO. 18-17

1—PLACE OF DEATH

TY OF BALTIMORE: (No.) Maryland General Hospital ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Pittroff

(a) RESIDENCE NO. 1900 E. Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Widowed

married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Oct 25, 1846

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	9	0	

CCUPATION OF DECEASED

a) Trade, profession or particular kind of work None

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

RTHPLACE (city or town) (State or country) Maryland

0 NAME OF FATHER Henry Engel

1 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

2 MAIDEN NAME OF MOTHER Catherine Sparmer

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Hospital records

(Address)

1930, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1930

17 I HEREBY CERTIFY, That I attended deceased from July 15 1930, to July 25 1930,

that I last saw h[illegible] alive on July 25 1930

and that death occurred, on the date stated above, at 6:45 p.m. S.T.

The CAUSE OF DEATH* was as follows:

Fracture left femur

(over)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert V. Amoruso, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL July 28 1930

20 UNDERTAKER John Allen

ADDRESS 2008 Eutaw

ec.—1-30—M. & T.—250 Blks

E 59181 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59181

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH (a) CITY OF BALTIMORE, (NO.) President Stop St. 15-21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Whittaker

(a) RESIDENCE NO. 734 Cumberland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

If married, widowed, or divorced (HUSBAND) of (or) WIFE of ———

DATE OF BIRTH (month, day, and year) Jan 26 1918

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	12	5	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

BIRTHPLACE (city or town) York (State or country) Va

10 NAME OF FATHER Austin Whittaker

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

Informant Mary Whittaker (Address) 734 Cumberland St

Date July 29, 1930 Registrar [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1930

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to July 24, 1930, that I last saw h— alive on July 24, 1930, and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows: Appendicitis (Ruptured)

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Peritonitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? Yes Date of July 23, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) B Hamm, M. D.

19 (Address) President Stop

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
York Town Va	July 26 1930
UNDERTAKER Mac R. G. Elliott	ADDRESS 1725 Ashland Ave

1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59182

1944 E 59182

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 14-20 Ward)

2-FULL NAME Alexander Moore

(a) RESIDENCE NO. 543 Mosher St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer Calvert Co

9 BIRTHPLACE (city or town) Calvert Co
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Moore

11 BIRTHPLACE OF FATHER (city or town) Calvert Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co
(State or country) Md

14 Informant Wm Moore
(Address) 1040 Brantley St

15 Filed ..., 19.. Registrar

6 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Prostration

(duration) ... yrs. hours mos. ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. E. Leuth M. D.

July 21st (Address) Bowie

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	July 26 1930
20 UNDERTAKER	ADDRESS
Joseph A Lively	409 Fremont Ave

Spec.—1-30—M. & T.—250 Blks

E 59183 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59183

38

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 17-26 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Hampton

(a) RESIDENCE NO. 713 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) May 30, ?

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	1	2?	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Staunton

(State or country) Va.

10 NAME OF FATHER George ?

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Bertha ?

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

Informant Records of

(Address) Balto. City Hosp.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22-30

17 I HEREBY CERTIFY, That I attended deceased from 7-8-30, 19..., to 7-22-30, 19...,

that I last saw her alive on 7-22-30, 19...,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis of central Nervous system; tabo paresis.

(duration) More than yrs. 2 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical, Wasserman.

(Signed) Dave Padgett, M. D.

7-24, 19... (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Clinton Staunton Va

DATE OF BURIAL 7/26 1930

20 UNDERTAKER Daniel Eaton

ADDRESS 916 Pa Ave

C. HARRISON JONES, M.D.

AUG 6 1930

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59184

E 59184

CERTIFICATE OF DEATH

REGISTERED NO. 13

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 555 Oxford (WARD)

2-FULL NAME Debora Maker

(a) RESIDENCE NO. 555 Oxford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) May 2 1930

7 AGE Years | Months 2 | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

10 NAME OF FATHER Clifton Maker

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Dorothy Fielding

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia
(State or country) Pa

14 Informant Dorothy Maker
(Address) 555 Oxford

Filed 2 6 1930, 192 Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 26th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. H. Gluck, M. D. Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn | DATE OF BURIAL 7/26/30

UNDERTAKER Samuel Evans | ADDRESS 916 Pa Ave

-30—M. & T.—100 B—501.

E 59185

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59185

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 702 Dolphin ST. 17-24 (WARD) 194

2-FULL NAME Wm H Caesar

(a) RESIDENCE NO 702 Dolphin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Caesar

DATE OF BIRTH (month, day, and year) May 9 1877

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	3	16	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pool room
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Henry Caesar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fredericksburg Va

12 MAIDEN NAME OF MOTHER Mary Murdock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

Informant Julia Caesar

(Address) 702 Dolphin

Filed ..... 192 ..... Registrar

C. HAMPSON JONES, M.

01930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Prostration

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ..... M. D.
Coroner

....., 19 (Address) Crane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL July 27 1930

20 UNDERTAKER Samuel D Hawley — ADDRESS 578 N Bradford

ec.—1-12-23—M&T—500 Bks.

E 59186 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59186

CERTIFICATE OF DEATH.

REGISTERED NO. 88

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 W Saratoga ST. 14-77 WARD)

2-FULL NAME Welcher Dorsey

(a) RESIDENCE No 1406 W Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Helen Dorsey

DATE OF BIRTH (month, day, and year) Feby 28, 1890

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	4	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman - Street Cleaning Dept.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER John Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Geo. A. Dorsey

(Address) 1406 W Saratoga

Filed 6 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1930

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1930, to July 23, 1930, that I last saw h[illegible] alive on July 23, 1930, and that death occurred, on the date stated above, at 8.10 p m.

The CAUSE OF DEATH* was as follows:

Acute Bacterial Endocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. H. Hoeffle, M. D.

(Address) 601 N Carrollton Ave

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loc. Auburn Cem. DATE OF BURIAL July 30

20 UNDERTAKER Samuel Kemsley ADDRESS 518 Eddie

ec.—1-30—M. & T.—200 Blks

E 59137 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59137

CERTIFICATE OF DEATH. X 100-00

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.) Provident Hospital (STREET AND) 14-20

2-FULL NAME Samuel Coston

(a) RESIDENCE NO. 1619 Druid Hill Ave WARD New York City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Coston

DATE OF BIRTH (month, day, and year) June 1865

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	1		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Preacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Princess Anne

(State or country) Md

10 NAME OF FATHER Samuel Coston

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Lydia Crane

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

Informant Lucy Coston

(Address) 266 W 120th St N.Y.C.

6-1930. C. HAMPSON JONES, M. D., Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24-30

17

I HEREBY CERTIFY, That I attended deceased from July 17, 1930, to July 24, 1930,

that I last saw him alive on July 24, 1930,

and that death occurred, on the date stated above, at 1:50 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Primary

(duration) yrs. 1 mos. 2 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill

DATE OF BURIAL July 26 30

20 UNDERTAKER Samuel T Bursley

ADDRESS 1701 Bolton St

...ec.—1-30—M. & T.—250 Bks.

E 59188 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59188

CERTIFICATE OF DEATH.

160

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3806 Mt Pleasant Ave ST., 26 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Powell

(a) RESIDENCE NO. 3806 Mt Pleasant Ave ST., 26 WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) July 25 1930

AGE: Years | Months | Days | If LESS than 1 day, ... hrs. or 20 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER Vernon Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER Lillian Grausell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

Informant: Vernon Powell
(Address) 3806 Mt. Pleasant Ave

Filed 6-1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1930

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930 to July 25, 1930, that I last saw him alive on July 25, 1930, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Premature

(duration) ... yrs. 0 mos ... ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Dr. [illegible] M. D.

7/26/30 (Address) 330 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: July 26 1930

20 UNDERTAKER: Lilly & Zieler Inc. — ADDRESS: 4038 Wolfe St

...—2-29-28—L. F. S.—500 Blks.

Lillie E. Travers

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59189

CERTIFICATE OF DEATH

100-001

E 59189

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 125 Birchwood ST. 23-31 WARD)

2—FULL NAME Lillie E Travers

(a) RESIDENCE NO. 125 Birchwood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 8 yrs. 1 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

ATE OF BIRTH (month, day, and year) May 29, 1922

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
8	1	26	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Baltimore Md
(State or country)

10 NAME OF FATHER Thomas Travers

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Susie Peters

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

Informant Susie Travers

(Address) 125 Birchwood Ave

HAMPSON JONES, M. D.

Filed ..., 19 ... Registrar

6 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28/30

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1930, to July 28, 1930, that I last saw her alive on July 24, 1930 and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

about 5
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys

(Signed) Wm E Stifler, M. D.

7/26, 1930 (Address) 1349 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Hill	7/28 1930
20 UNDERTAKER L. H. McCully	ADDRESS 130 E Fort

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59190

CERTIFICATE OF DEATH

100-001

E 59190

REGISTERED NO. 28-31

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Caraway

(a) RESIDENCE NO. 910 S. Sharpe ST., WARD 22
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 0 yrs. 9 mos. 25 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Oct. 1, 1929

GE	Years	Months	Days 24	If LESS than 1 day, ...hrs. or ....min.
	0	9	25	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Baltimore
(State or country)

0 NAME OF FATHER Irvin

1 BIRTHPLACE OF FATHER (city or town) Morehead C.
(State or country) N. C.

2 MAIDEN NAME OF MOTHER Helen Thomas

3 BIRTHPLACE OF MOTHER (city or town) Richmond
(State or country) Virginia

Informant Helen Caraway (mother)

(Address) 910 S. Sharpe St

C. HARRISON JONES, M.D.

Registrar

6 1930 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1930

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1930, to July 25, 1930

that I last saw him alive on July 25, 1930

and that death occurred, on the date stated above, at 6:25 A.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 910 S. Sharpe Street

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Joseph H. Sharp, M.D.

, 19 (Address) Sydenham

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

UNDERTAKER Walter D. Spriggs

DATE OF BURIAL 7/26 1930

ADDRESS 139 W. Hamburg St

Dec.—1-30—M. & T.—250 Bks

E 59191 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59191

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. S. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shelton Goesberry

(a) RESIDENCE NO. 1426 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Virginia

DATE OF BIRTH (month, day, and year) Dec. 1, 1880

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	7	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) out of work

(c) Name of employer

BIRTHPLACE (city or town) Brunswick Co.

(State or country) Va.

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Emma Edmonds

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

Informant Records of

(Address) Balto. City Hosp.

Filed 6-1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24-30

17 I HEREBY CERTIFY, That I attended deceased from 7-18-30, 19..., to 7-24-30, 19...,

that I last saw him alive on 7-24-30, 19...,

and that death occurred, on the date stated above, at 4:45 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padget, M. D.

7-25-30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	July 21 1930
20 UNDERTAKER Walter B. Spriggs	ADDRESS 139 W. Hamburg St.

ec.—1-12-23—M&T—500 Bks.

E 59192

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59192

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Jenkins Memorial Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1000 Eaton Ave ST. 8-13 WARD)

2-FULL NAME Mrs Mary Wallace

(a) RESIDENCE NO. 1262 Washington Blv. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Married~~ Widow

If married, widowed, or divorced HUSBAND ~~of~~ (or) WIFE of the late Chas H Wallace.

DATE OF BIRTH (month, day, and year) March 4-1856

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74 yrs.		4	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Maryland

10 NAME OF FATHER: Charles Gitzendanner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

Informant: Jenkins Mem. Hospital

(Address): 1000 Eaton Ave

Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

No. 1930 Reg. 1014

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26th 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1930, to July 26, 1930, that I last saw h.. alive on July 26, 1930, and that death occurred, on the date stated above, at 3:00 A.m.

The CAUSE OF DEATH* was as follows:

Hypertension C.V. disease

Hemiplegia

(duration) 4 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

Cardiac failure (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. T. Brady, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: July 29th 30

20 UNDERTAKER: John J Cowan & Son ADDRESS: 901 Hollins St.

ec.—1-30—M. & T.—250 Bks.

E 59193

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59193

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

2-FULL NAME Jacob H. Handley.

(a) RESIDENCE NO. Westminster Md. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) April 4. 1856

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	3	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Carroll Co Maryland

10 NAME OF FATHER Levi Handley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Stonesifer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Harry W. Handley

(Address) Westminster Md

Filed 7 1930 C. RAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 11th, 1930, to July 26th, 1930, that I last saw h.. alive on July 26th, 1930, and that death occurred, on the date stated above, at 6.35 p.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

Duration unknown- Symptoms for about 2 months. (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of —

Was there an autopsy? Partial.

What test confirmed diagnosis?

(Signed) W. F. Verdi, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Kriders — DATE OF BURIAL July 29 1930

UNDERTAKER H Bankard & Son — ADDRESS Westminster Md

...—1-30—M. & T.—250 Blks.

238981 E 59194

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59194

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (NO. 1-9 ST., WARD)

2-FULL NAME Leonard Nolker

(a) RESIDENCE NO. Elkridge Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

If married, widowed, or divorced HUSBAND of or) WIFE of Agnes

DATE OF BIRTH (month, day, and year) Dec. 1904

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	7		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER John Nolker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Records JOHNS HOPKINS HOSPITAL (Address)

Filed 7-1930. 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26-1930

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to July 26, 1930, that I last saw him alive on July 26, 1930, and that death occurred, on the date stated above, at 12 50 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor - cerebellar
cyst left - cuneiform
Hemangioma.

(duration) 18 yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-22-30

Was there an autopsy? no

What test confirmed diagnosis? Operation —

(Signed) Fred W Sweet, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Augustines Cem. Elkridge Md

DATE OF BURIAL 7/29 1930.

UNDERTAKER John J Cowan & Son

ADDRESS 901 Dallas St

ec.—1-30—M. & T.—250 Blks

E 59195 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59195

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO. 25-32

ITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Blutcher

(a) RESIDENCE NO. 2303 Sidney ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Blutcher

DATE OF BIRTH (month, day, and year) Feb.9,1875

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55	5	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Richard T. Blutcher

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Maryland

Informant Hospital Records

(Address)

Filed 7-27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 19 ..., 1930 to July 25, 1930,

that I last saw him alive on July 25, 1930,

and that death occurred, on the date stated above, at 10.15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerotic cardio-vascular renal disease yrs. Unknown mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Jenner, M. D.

7-26 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	7/29/1930
20 UNDERTAKER Wm. Cook	ADDRESS 1217 St Paul St

...—2-29-28—L. F. S.—500 Bks.

E 59196

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59196

CERTIFICATE OF DEATH

1930

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1713 (ST.) Thomas Ave (WARD) 18

2—FULL NAME Annie Davis Westerman

(a) RESIDENCE NO. 1713 Thomas Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If ~~married, widowed, or divorced~~ ~~HUSBAND OF~~ (or) WIFE of Francis H. Westerman

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	90			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Geo W. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Julia Baer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

Informant Frank Westerman

(Address) 1116 Poplar Grove St

Filed JUL 27 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1930, to July 26, 1930, that I last saw h.s.. alive on July 25, 1930 and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Senile arteris - sclerosis and chronic nephritis

(duration) over 2 mos 5 days.

CONTRIBUTORY (Secondary) Fracture of left thigh

(duration) yrs. 2 mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What confirmed diagnosis? Clinical Facts

(Signed) Henry C. Cole, M. D.

7-26, 1930 (Address) 1208 W. Lafayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 7/29/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

H. JAMES JONES, M. D. Registrar

ec.—1-30—M. & T.—250 Blks

E 59197

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59197

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 9-47

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

2-FULL NAME Glenn Felts

(a) RESIDENCE NO. 3930 Lowndes ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) June 21, 1904

GE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	26	1	4	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wireless operator

(b) General nature of industry, business, or establishment in which employed (or employer) Bull Steamship Co Unknown

(c) Name of employer Unknown

IRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER Lytle Felts

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Nancy McBride

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

Informant Hospital Records
(Address)

Filed 7 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1930, to July 25, 1930, that I last saw him alive on July 25, 1930, and that death occurred, on the date stated above, at 11.20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Jenner, M. D.

7-26 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine

DATE OF BURIAL 7/29 1930

20 UNDERTAKER J. M. Cook

ADDRESS 1217 E Pratt St

...c.—1-30—M. & T.—250 Blks

9198

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 59198

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 Maryland Ave ST. 17-51 WARD)

2-FULL NAME John R. Peel

(a) RESIDENCE No. 2204 Maryland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed or divorced HUSBAND of ~~or WIFE of~~ Addie K. Peel

DATE OF BIRTH (month, day, and year) 2/26 1861

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	69	5	0	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 66

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Mississippi

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Miss

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Miss

Informant Addie K. Peel

(Address) 2204 Maryland Ave

Filed JUL 27 1930 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/26/1930

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1930, to July 26, 1930, that I last saw him alive on July 26, 1930, and that death occurred, on the date stated above, at 11:20 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach resulting in obstruction

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) S. Kendig Wallace, M. D.

July 26, 1930 (Address) 2839 Walbrook Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL 7/28/1930

20 UNDERTAKER Wm. Cook — ADDRESS 1217 St Paul St

ec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59199

CERTIFICATE OF DEATH.

31 E 59199

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1922 Brunt ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Wilson

(a) RESIDENCE NO. 1922 Brunt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced, HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) June 8, 1916

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	14	1	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Wm Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lydia Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Lydia Wilson

(Address) 1922 Brunt St.

Filed July 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1930

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1930, to July 25, 1930.

That I last saw her alive on July 24, 1930,

and that death occurred, on the date stated above, at 12.25 p m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) C. F. Hagerty, M. D.

July 26, 1930 (Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL July 29 30

UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Preston St

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59200

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 59200

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

TY OF BALTIMORE: (No. 1107 Parrish ST. 16-27 WARD)

2—FULL NAME Sarah J. Watkins

(a) RESIDENCE NO. 1107 Parrish ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	widowed.

If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Watkins

ATE OF BIRTH (month, day, and year) 1845

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) (State or country) md.

0 NAME OF FATHER unknown

1 BIRTHPLACE OF FATHER (city or town) (State or country) "

2 MAIDEN NAME OF MOTHER "

3 BIRTHPLACE OF MOTHER (city or town) " (State or country)

Informant Carley Watkins.

(Address) 1107 Parrish St

FILED JUL 27 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23/30

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930 to July 23, 1930

that I last saw her alive on July 23, 1930

and that death occurred, on the date stated above at 3 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Degeneration,

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

7/16 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL July 27 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 50 Preston St

...ec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59201

16-002

CERTIFICATE OF DEATH

E 59201

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.) 640 N Carrollton Ave. WARD 16

2—FULL NAME Warren Mack

(a) RESIDENCE NO. 640 N Carrollton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Jul 23 1930

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		5	3	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) City
(State or country)

10 NAME OF FATHER John F. Mack

11 BIRTHPLACE OF FATHER (city or town)
(State or country) City

12 MAIDEN NAME OF MOTHER Florence Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) City

Informant Mrs. Florence Mack
(Address) 640 N Carrollton Ave

Filed 7-1930 C. H. JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1930

17

I HEREBY CERTIFY, That I attended deceased from July 23, 1930 to July 26, 1930

that I last saw him alive on July 26, 1930

and that death occurred, on the date stated above, at 4:35 A. m.

The CAUSE OF DEATH* was as follows:

Acute dysentery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 852 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 28 1930

20 UNDERTAKER Samuel E. Wright ADDRESS 700 N Carrollton Ave

ec.—1-12-23—M&T—500 Bks.

E 59202 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 129 E 59202

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen. Hosp ST. 1124 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Savvy Fink

(a) RESIDENCE NO. 305 W. Madison St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Fink

DATE OF BIRTH (month, day, and year) 1866

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia Poland

10 NAME OF FATHER Savvy Fink

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia Poland

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia Poland

Informant Harold I. Fink (Address) 3500 Forest Park Ave.

Filed 2-7 1930 H. MAURICE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/25 1930.

17 I HEREBY CERTIFY, That I attended deceased from 6/12, 1930, to 7/25, 1930, that I last saw h alive on 7/25/30, 19, and that death occurred, on the date stated above, at 10.20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Several years duration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Ashmeyer, M. D.

, 19 (Address) W. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew — DATE OF BURIAL 7-27-1930

20 UNDERTAKER Jack Laird, 1439 — ADDRESS E Balto St

ec.—1-30—M. & T.—250 Bks.

59203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 59203

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

ITY OF BALTIMORE: (No. 15-61 ST. Ward)

2-FULL NAME Sol Gordon

(a) RESIDENCE NO. 3621 Fairview Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) —

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Box Mfg.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Lida. Ina

10 NAME OF FATHER Isaac Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annis —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant. (Address) I. Gordon Lida Ind

Filed 7 27 1930 Phyllis Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 26, 30, to July 27, 1930, that I last saw him alive on July 27, 30, and that death occurred, on the date stated above, at 6:45 AM EST

The CAUSE OF DEATH* was as follows:

Chr. valvular disease (rheumatic) mitral stenosis & insufficiency aortic insufficiency

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Observation

(Signed) Milton B. Kirsh, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon Wash. Blvd	7-27, 30
20 UNDERTAKER	ADDRESS
Isador Levine, 1439	Balto

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59204 128 E 59204

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1842 E. Fort Ave. St. 24-35 Ward)

2-FULL NAME George E. Lent Jr.

(a) RESIDENCE NO. 1842 E. Fort Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 8 mos. 12 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced
HUSBAND of Mary Lent.

6 DATE OF BIRTH (month, day, and year) November 18, 1897

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	32	8	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Elevator operator.
(b) General nature of industry, business, or establishment in which employed (or employer) 686
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER George E. Lent Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Boston, Mass.

12 MAIDEN NAME OF MOTHER Sarah Simms.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Richmond, Va.

14 Informant Sarah Lent. (mother)
(Address) 1842 E. Fort Ave.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.
Uraemia.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto A. Rimsdt, M. D.

7/26 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill. DATE OF BURIAL July 29, 1930

20 UNDERTAKER Chas. P. Stearns ADDRESS 1529 Fort Ave

7 1930 C. HARRY JONES, M. D. Registrar

Houst

...c.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59205 E 59205

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Louise Houst

(a) RESIDENCE NO. 1817 West Lanvale St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed or divorced HUSBAND of or) WIFE of George Jean Houst

DATE OF BIRTH (month, day, and year) Aug 26th 1891

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	11	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer Self

BIRTHPLACE (city or town) Baltimore Md
(State or country)

10 NAME OF FATHER Fredkind Volker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Werner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Geo. G. Haupt

(Address) 1817 W. Lanvale

FILED JUL 27 1930 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/26/30

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 26, 1930,

that I last saw her alive on July 26, 1930,

and that death occurred, on the date stated above, at 3.50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Right Hemiplegia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical findings Autopsy,

(Signed) J. Edward Haupt, M. D.

7/26, 1930 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park

DATE OF BURIAL 7/30, 1930

20 UNDERTAKER Geo. Weber & Son

ADDRESS 2503 Edmondson

ec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59206

CERTIFICATE OF DEATH.

90 E 59206

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 1806 Bank ST., 24 WARD)

2-FULL NAME Bertha T. Roesnicke

(a) RESIDENCE NO. 1806 Bank ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of the late Geo. A. Roesnicke

DATE OF BIRTH (month, day, and year) Feb. 11th 1864

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	5	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Hartford Co.

10 NAME OF FATHER Edward Dunnigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Tilypatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24th 30

17 I HEREBY CERTIFY, That I attended deceased from 7-14-, 1930, to 7-24-, 1930, that I last saw h[illegible] alive on 7-20, 1930, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Valvular heard disease (duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Dr. Heller M.D.

7-25-1930 Address 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Informant Mary M. Watson Daughter

Address 1806 Bank St

7-28-1930 HAMILTON JONES, M. D.

Filed 19 Registrar

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL July 28 1930

20 UNDERTAKER Lidz & Julian Sch

ADDRESS 403 S. Wolfe St

...ec.—1-30—M. & T.—250 Bks.

E 59207 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59207

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 711 S. East Ave ST., 26-1 WARD)

2-FULL NAME Frances Metzger.

(a) RESIDENCE NO. 711 S. East Ave ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Joseph Metzger.

DATE OF BIRTH (month, day, and year) Dec 12th 1873

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
56	7	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER John Geberlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Apolonia Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Joseph Metzger (Husband)

(Address) 711 S. East Ave.

C. HASLETON JONES, M. D.

Filed 7 1930 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25th 30.

17 I HEREBY CERTIFY, That I attended deceased from January, 19 27 to July 25, 19 30.

that I last saw her alive on July 1st, 19 30;

and that death occurred, on the date stated above, at 11.40 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Diabetes

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? C

(Signed) Joseph Toomey M. D.

, 19 (Address) 8005 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery DATE OF BURIAL July 28 1930

UNDERTAKER Lilly & Sullivan ADDRESS 403 S. Mount St

ec.—2-29-28—L. F. S.—500 Bks.

E 59208 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 59208

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.) 511 Jayne Ave ST. 20-78 (WARD)

2—FULL NAME Bernard R Comacost

(a) RESIDENCE NO. 511 Jayne Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Anna R Comacost

7 DATE OF BIRTH (month, day, and year) Sept 23 1899

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Govt Arsenal 086

(b) General nature of industry, business, or establishment in which employed (or employer) Employee

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER William Comacost

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Rouston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mrs R Comacost

(Address) 511 Jayne Ave

Filed 2-7 1930, Registrar

EMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1930

17 I HEREBY CERTIFY, That I attended deceased from July 14 1930 to July 25 1930

That I last saw him alive on July 25 1930 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) few hours. yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Pathological

(Signed) Augustus P. Vonschuck M.D.

(Address) 1416 E Edmondson Ave. 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lakeside Crem DATE OF BURIAL 7/28 1930

20 UNDERTAKER Frye & Farley ADDRESS Fulton & Fayette

...ec.—1-30—M. & T.—250 Bks.

E 59209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 E 59209

REGISTERED NO.....

1-PLACE OF DEATH Sunway Apts ST 17-44 WARD)

ITY OF BALTIMORE. (No.

2-FULL NAME William Mann Carswell

(a) RESIDENCE NO. Sunway Apts ST., ... WARD Daytona Beach Fla.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? 67 yrs. 10 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of Single

DATE OF BIRTH (month, day, and year) August 26 1862

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	10	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer none

BIRTHPLACE (city or town) Janesville
(State or country) Wisconsin

10 NAME OF FATHER Lockhart B. Carswell

11 BIRTHPLACE OF FATHER (city or town) Payson
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Emma Mann

13 BIRTHPLACE OF MOTHER (city or town) Brattleboro
(State or country) Vermont

Informant Mrs Inez C Thurman Sister
(Address) Sunway Apts.

Filed 7 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 25 1930

17 I HEREBY CERTIFY, That I attended deceased from July 25 1930 to July 25 1930, that I last saw him alive on July 25 1930, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Thrombotic Coronary Occlusion
Angina attack, death time only
one hour before his death mos 1 ds.
CONTRIBUTORY (Secondary) Pain about 24 hours (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Inject

(Signed) M. Gibson Boykin, M. D.

7/26 1930 (Address) 4822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fort Lincoln Cemetery Maryland DATE OF BURIAL July 28 1930

20 UNDERTAKER Stewart Memorial Co ADDRESS Balto

ec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

59210

CERTIFICATE OF DEATH.

90 E 59210

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No.) 3610 Clifton St. (WARD) 15 bl

2-FULL NAME William Emmert Glascock

(a) RESIDENCE NO. 3610 Clifton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Margaretta Glascock

DATE OF BIRTH (month, day, and year) June 10 - 1884

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46		1	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager 086

(b) General nature of industry, business, or establishment in which employed (or employer) Bottle Manufacturing

(c) Name of employer Owens Illinois Glass Co

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Charles Glascock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Catherine Emmert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

Informant Margaret T. Glascock

(Address) 3610 Clifton Ave.

Filed JUL 27 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1930 to July 26, 1930

that I last saw him alive on July 26, 1930

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis.

Cardiac Hypertrophy.

Interstitial Glomerulonephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. H. Woodey, M. D.

, 19 (Address) 140 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL July 28 1930

20 UNDERTAKER H. Friedman Sons

ADDRESS N. & Pa.

ec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59211

CERTIFICATE OF DEATH

49 E 59211

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 2730 Fenwick Ave ST. 13-51 WARD)

2—FULL NAME John W. Wittig

(a) RESIDENCE NO. 2730 Fenwick Ave ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

ngth of residence in city or town where death occurred Life ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Wittig

ATE OF BIRTH (month, day, and year) Sept. 18, 1882

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	10	8	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of indastry, business, or establiishment in which employed (or employer) —

(c) Name of employer —

IRTHPLACE (city or town) (State or country) Balto. Md.

0 NAME OF FATHER Fred W. Wittig

1 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

2 MAIDEN NAME OF MOTHER Anna K Engle

3 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

Informant Mr Minnie Wittig

(Address) 2730 Fenwick Ave

Filed 2 7 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 '30

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1929, to July 26, 1930

that I last saw h alive on July 26, 1930

and that death occurred, on the date stated above, at 11.10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma left foot with metastases to popliteal space & groin

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb 28 '29

Was there an autopsy? No June 25, '29

What test confirmed diagnosis? Microscopic

(Signed) Grant E. Ward, M. D.

, 19 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	July 29 1930
20 UNDERTAKER Wm. J. Tschudy & Son	ADDRESS Balto.

E 59212

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital — REGISTERED NO. 12-50

CITY OF BALTIMORE: (NO. ..... ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma L Stephens

(a) RESIDENCE NO. 2426 St. Paul ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., if of foreign birth? ✓ yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. W. Stephens

DATE OF BIRTH (month, day, and year) June 1st - 1855

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	1	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Diedrich Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Dinkel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. Edwin W. Hausman, nurse

(Address) 2641 N. Calvert

Filed JUL 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1930, to July 25, 1930, that I last saw h.e. alive on July 25, 1930, and that death occurred, on the date stated above, at 7:55 p.m. (Bn., Lg., or Surg.)

The CAUSE OF DEATH* was as follows:

Cerebral Accident

Primary cause unknown

(duration) ..... yrs. 2 mos 14 ds.

CONTRIBUTORY (Secondary) Cerebral accident (Hemorrhage)

(duration) ..... yrs. 2 mos. 14 ds.

18 Where was disease contracted if not at place of death? 2426 St Paul St. City.

Did an operation precede death? No. Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical course.

(Signed) Jesse Lipes, M. D.

July 25 1930 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL July 28 1930

UNDERTAKER H. J. Pedersen Son

ADDRESS North Ave

sec.—1-30—M. & T.—250 Bks

59213

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59213

91-002

CERTIFICATE OF DEATH.

REGISTERED NO. 59213

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 217 Cedar Croft Rd ST. 27-48 WARD

2-FULL NAME Emma Louise Ogles

(a) RESIDENCE NO. 217 Cedar Croft Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Adolph Ogles

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Adolph Ogles

(Address) 217 Cedar Croft Rd

Filed JUL 31 1930 H. LAWRENCE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1930

17 I HEREBY CERTIFY, That I attended deceased from June 8th 1930, to July 26 1930,

that I last saw h. alive on July 25th 1930,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. S. Stone M. D.

July 26, 1930 (Address) 4900 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL July 29 1930

20 UNDERTAKER H. J. Tedesco Co

ADDRESS North

Spec.—8-16-29—L. F. S.—100 Bks.

59214

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. [redacted]

1—PLACE OF DEATH U.S. Marine Hospital

CITY OF BALTIMORE: (No. Baltimore, Md. ST. 12-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas E. Manning

(a) RESIDENCE NO. 48 Rausch St., San Francisco, Calif. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Kahn

DATE OF BIRTH (month, day, and year) April 23, 1884

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	3	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 1st Asst. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS Sacramento

BIRTHPLACE (city or town) San Francisco

(State or country) California

10 NAME OF FATHER George W. Manning

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Hannah E. Morris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

Informant Records, U.S. Marine Hospital

(Address) Baltimore, Md.

Filed AUG 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1930 to July 25, 1930,

that I last saw him alive on July 25, 1930

and that death occurred, on the date stated above, at 5:45 P.m.

The CAUSE OF DEATH* was as follows:

Gastritis, acute

[redacted]

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Atelectasis (massive collapse of lungs) (duration) one hour yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [redacted], M. D.

7/26, 1930 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's, Hampden — DATE OF BURIAL July 28, 1930

20 UNDERTAKER E. Leroy Stubblefield Inc. — ADDRESS 125 E. North ave.

Little

...c.—1-30—M. & T.—250 Blks.

E 59215 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59215

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1627 N. Calhoun St. WARD 15-21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Little

(a) RESIDENCE NO. 1627 N. Calhoun WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of John Little

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
50			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Frederick Md.

(State or country)

10 NAME OF FATHER Frederick Fredericks

11 BIRTHPLACE OF FATHER (city or town) Frederick Md.

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

Informant Family Physician

(Address) 1707 Division

Filed JUL 28 1930 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1930

17 I HEREBY CERTIFY, That I attended deceased from May 30, 19 ... to July 26, 19 30

that I last saw her alive on July 25, 19 1930

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Regester M. D.

(Address) 1707 Division St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL July 28 19 30

UNDERTAKER A. S. Marshall ADDRESS 353 Hall Rd

Spec.—1-10-21—M&T—1500 Bks. Addie Kelsey

HEALTH DEPARTMENT—CITY OF BALTIMORE

59216

CERTIFICATE OF DEATH.

74-001

E 59216

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412-W 25 ST. 12-51 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Addie Kelsey

(a) RESIDENCE NO. 412-W 25 ST. 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Kelsey.

6 DATE OF BIRTH (month, day, and year) June 28 1869.

7 AGE Years 61 Months Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Daniel Gaither

11 BIRTHPLACE OF FATHER (city or town) md.

(State or country)

12 MAIDEN NAME OF MOTHER Priscilla Bailey

13 BIRTHPLACE OF MOTHER (city or town) md.

(State or country)

14 Informant (Address) Mrs. Hendel 412-W 25th St.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1930

17 I HEREBY CERTIFY, That I attended deceased from July 21 1930 to July 25 1930

that I last saw her alive on July 25 1930

and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac Arteriosclerosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Roscoe Gross M. D.

(Address) 2438 Maryland Ave

7-26 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn.

DATE OF BURIAL July 28 1930

20 UNDERTAKER Chenowith Son

ADDRESS 3610 Gwynn Oak Ave.

pec.—1-30—M. & T.—250 Blks

E 59217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160

E 59217

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 811 W 38 ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Allen Mathias Jr

(a) RESIDENCE NO. 811 W 38 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) July 20 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	✓	✓	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ (ans)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) md

10 NAME OF FATHER Arthur A Mathias

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Oriolae Hoover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

Informant Arthur Mathias

(Address) 811 W 38 St

C. HAMPSON JONES, M. D.

Registrar

F[illegible] 1930 by

8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1930

17 I HEREBY CERTIFY, That I attended deceased from 7/20, 1930, to 7/27, 1930, that I last saw him alive on 7/27, 1930, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Tetanus Neonatorum

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

2/28 1930 (Address) 2020 N. Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	July 28 1930
20 UNDERTAKER	ADDRESS
Chenowith & Son	3617

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59218

CERTIFICATE OF DEATH.

49 E 59218

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 4510 Ristertown Road ST. 27-56 (WARD)

2-FULL NAME Louis Kemper

(a) RESIDENCE NO. 4510 Ristertown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Ida Kemper

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Morton Kemper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hannah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant J. Louis (Address) 1429 E Balto St.

Filed 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 30

17 I HEREBY CERTIFY, That I attended deceased from April 16, 19 30, to July 27, 19 30, that I last saw him alive on July 25, 19 30, and that death occurred, on the date stated above, at 11 30 A m. P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of bronchus, of Rt. lung,

(duration) about one yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Findings

(Signed) Nathan A. Shapiro, M. D.

19 (Address) 2318 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Wash. Cem

DATE OF BURIAL 7-28-19 30

ADDRESS

20 UNDERTAKER Jack Louis, 1429 E Balto St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59219

E 59219

CERTIFICATE OF DEATH

182

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found floating in the water

City of Baltimore: (No. at 500 Ft. Span Honover St Bri St., 9c. 4th Ward)

2-FULL NAME William S. Hyman.

(a) RESIDENCE NO. 2537 Robb St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 9 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced
HUSBAND of Mabel V. Hyman.

6 DATE OF BIRTH (month, day, and year) October 12, 1903

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	26	9	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Trucker,
(b) General nature of industry, business, or establishment in which employed (or employer) B.& O.R.R.Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Hyman.

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Leona O'Brian.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.
(State or country)

14 Informant Mabel V. Hyman. (wife)
(Address) 2537 Robb St.

Filed JUL 28 1930 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July ~~24~~, 1930 found July 26, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental Drowning while crabbing.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt M. D.

7/27, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 7/28/30

ADDRESS

20 UNDERTAKER Geo. D. Pulk Inc. 1735 Hoffman

pec.—1-30—M. & T.—250 Bks.

E 59220 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59220

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 8-12 WARD)

2-FULL NAME Rose Lippert

(a) RESIDENCE NO. 2322 Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Caspar Lippert

DATE OF BIRTH (month, day, and year) 3 12 1859

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	4	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Tuseck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mr Caspar Lippert

(Address) 2322 E Biddle St

Filed 2 6 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26-30

17 I HEREBY CERTIFY, That I attended deceased from 7-23-30, 19..., to 7-26-, 19 30, that I last saw h alive on 7-26-30, 19..., and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis + Myocarditis

(duration) ...yrs. ...mos 3 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ...yrs. ...mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) M B Kuchenmeister, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk Cem — DATE OF BURIAL 7 29 1930

UNDERTAKER C W & E H Hilts Jr 1606 N Charles St — ADDRESS

pec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59221

59221

CERTIFICATE OF DEATH.

1930

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) University of Md ST. 20-69 WARD

2-FULL NAME Charles W. Heintz

(a) RESIDENCE NO. 2560 Fulton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 6 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced (HUSBAND of or) WIFE of: Ida Heintz

DATE OF BIRTH (month, day, and year): Jan 13th 1891

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	6	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer): 806

(c) Name of employer

BIRTHPLACE (City or town) (State or country): Baltimore, Md

10 NAME OF FATHER: Louis Heintz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Apple

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

Informant: Catherine Heintz

(Address) 2679 Druid Hill Ave

Filed FEB 8 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/25/30

17 I HEREBY CERTIFY, That I attended deceased from 7/25, 19 30, to 7/25, 19 30, that I last saw h.. alive on 7/25, 19 30, and that death occurred, on the date stated above, at 12:50 P.M. S.T.

The CAUSE OF DEATH* was as follows:

Heart prostration

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at work.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Henry D. Mitchell, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 7/29/30

UNDERTAKER: A. D. Philpott

ADDRESS: 1850 W. Pratt St

Spec.—1-10-21—M&T—1500 Blks.

59222

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 J

E 59222

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2506 W. Fayette ST. 70-64 WARD)

2-FULL NAME Sophia Neary

(a) RESIDENCE NO. 2506 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Wm G. Neary

6 DATE OF BIRTH (month, day, and year) June 14th 1887

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
43	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

10 NAME OF FATHER Peter Leithauser

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Helen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ohio

14 Informant Wm G. Neary

(Address) 2506 W. Fayette St

Filed 7-28-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 10, 1930, to July 20, 1930,

that I last saw h-e alive on July 20, 1930,

and that death occurred, on the date stated above, at 9.50 P. m. STANDARD

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Glioma - Brain

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 7, 1930

Was there an autopsy? no.

What test confirmed diagnosis? Clinical - Pathology.

(Signed) Wm. A. Strauss, M. D.

7/20, 1930 (Address) 1901 Guilford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 7/28/30

UNDERTAKER F. B. Klapfer

ADDRESS 1850 N. Bath St

Spec.—1-30—M. & T.—250 Bks.

33 9085
E 59223

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 E 59223

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 1074 ST. WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Thompson

(a) RESIDENCE No. 1214 N. Elderry ST., 5th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Child

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 31-1929

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Md —
(State or country)

10 NAME OF FATHER John Thompson

11 BIRTHPLACE OF FATHER (city or town) Md —
(State or country)

12 MAIDEN NAME OF MOTHER Amy Thompson

13 BIRTHPLACE OF MOTHER (city or town) D.C —
(State or country)

Informant Records —
(Address) JOHNS HOPKINS HOSPITAL

Filed 7-28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25-30

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1930, to July 25, 1930, that I last saw h[illegible] alive on July 25-, 1930, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

retrophayngeal abscess
secondary bronchopneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 19, 1930

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J M Bickford, M. D.

7/26 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leakin Park Cem.

DATE OF BURIAL 7-28 1930

20 UNDERTAKER Byron & Wright 218 N. Elderry St

ADDRESS

ec.—1-30—M. & T.—250 Rts

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59224

CERTIFICATE OF DEATH.

90 E 59224

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS ST. 21-21 WARD

ITY OF BALTIMORE: (No.) ST.,

2-FULL NAME Charles Granger

(a) RESIDENCE NO. 1028 Denver St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed.

If married, widowed, or divorced HUSBAND of (or) WIFE of unknown.

DATE OF BIRTH (month, day, and year) 1862.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer. do

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore. md.

10 NAME OF FATHER Mason Granger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md.

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

Informant (Address) Record of BALTIMORE CITY HOSPITALS

Filed 7-28 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1930.

17 I HEREBY CERTIFY, That I attended deceased from January 25, 1927 to July 27, 1930.

that I last saw h[illegible] alive on July 27, 1930,

and that death occurred, on the date stated above, at 2:20 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic, arteryio sclerotic

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? 1. Home. 2. Hospital

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget. M. D.

7-27 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 7/30 1930

20 UNDERTAKER Wm Cook 1217 St

ADDRESS Paul st

sec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59225

E 59225

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caulton & Oliver ST 21-29 WARD)

REGISTERED NO. 118

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Weaver

(a) RESIDENCE NO. 750 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa May Weaver

DATE OF BIRTH (month, day, and year) Aug 22nd 1870

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	11	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Guard

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Grail Electric Co

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER John Weaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Barbara Bremenmun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mr Jennie Weaver

(Address) 819 Burgundy St

FILED 2 8 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27/30

17 I HEREBY CERTIFY, That I attended deceased from 7-10, 1930 to 7-27-1930,

that I last saw him alive on 7-26, 1930

and that death occurred, on the date stated above, at 4 00 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Femoral Hernia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7/18/30 and 7/24/30

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Cook, M. D.

, 19 (Address) 12 Saint Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 7/29/1930

UNDERTAKER Wm Cook 12 St Paul St

ADDRESS

...ec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59226

E 59226

REGISTERED NO. 1645

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2853 W Lafayette Ave ST. 16-66 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henrietta Allen

(a) RESIDENCE NO. 2853 W Lafayette ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

If married, widowed, or divorced: HUSBAND of (or) WIFE of: Richard B Allen

DATE OF BIRTH (month, day, and year): Aug 8, 1852

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	11	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

BIRTHPLACE (city or town) (State or country): Norfolk Va

10 NAME OF FATHER: Daniel L Cherry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga

12 MAIDEN NAME OF MOTHER: Lilly Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ga

Informant: Edna B Custis

(Address) 2853 Lafayette Ave

Filed 1 AUG 1930 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2 yrs ago, 19 to July 25, 1930, that I last saw her alive on July 25 1930 and that death occurred, on the date stated above, at 3.50 p m.

The CAUSE OF DEATH* was as follows:

Senility

about 2 years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical record

(Signed) Marie L. Lingram, M. D.

19 (Address) 2439 N Charles St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine

DATE OF BURIAL: 7/30 1930

20 UNDERTAKER: Fulton Cook

ADDRESS: 1217 E Pratt St

...ec. 1-30 M. & T.—250 Blks.

59227 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 59227

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

2-FULL NAME Annie Bell

(a) RESIDENCE NO. Preston & Valley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 23 Oct 1837

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	93	9	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work do

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER Thadius Douglas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz. Cookman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Little Sisters of the Poor
(Address) Preston & Valley St

Filed JUL 30 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 27 July 1930

17 I HEREBY CERTIFY, That I attended deceased from 7/24, 1930, to 7/27, 1930, that I last saw h... alive on 7/26, 1930, and that death occurred, on the date stated above, at 11 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic Cardiitis
Contributory (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Dr Bernard Wolff M. D.

(Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 30 1930
UNDERTAKER	ADDRESS
M. W. & Hoppe	37 S Carey

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113

E 59228

REGISTERED NO. E 59228

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Johns Hopkins Hospital St., (Ward)

2-FULL NAME Bernard Lozyk

(a) RESIDENCE NO. 702 S. Luzerne St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 10 - 30

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		7	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Paul Lozyk

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Dorothy Michalek

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto.

14 Informant A. Michalek
(Address) 702 S. Luzerne

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) 2 yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Ch. Pancreas

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? History

(Signed) ..... M. D.
(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL July 28 30

20 UNDERTAKER F. Ozazewski

ADDRESS 1720 Eastern

...ec.—1-30—M. & T.—250 Blks.

E 59229 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59229

CERTIFICATE OF DEATH.

REGISTERED NO. 5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST., 2-4 (WARD)

2-FULL NAME Gerard Imaras

(a) RESIDENCE NO. 2023 Bank ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

If married, widowed, or divorced (HUSBAND) of (or) WIFE of

DATE OF BIRTH (month, day, and year) August 2-1918

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
11	11	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Marty J. Imaras.

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Veronica Tamba

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

Informant Mr Marty J. Imaras.

(Address) 2023 Bank Street

Filed ... 19... E. HAMPSON JONES, M. D. Registrar

8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27/30

17

I HEREBY CERTIFY, That I attended deceased from 7-14, 1930, to 7-27, 1930,

that I last saw him alive on 7-21 30, 19...;

and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Carditis

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) W. McGuidey, M. D.

, 19... (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Thomas Cemetery	July 30 1930
20 UNDERTAKER	ADDRESS
George A. Weber	705 Lanvale St.

...c.—1-30—M. & T.—250 Blks

59230 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59230

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.) S. 1 WARD)

2-FULL NAME Mary Majka

(a) RESIDENCE NO. 1602 E Fleet Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	—

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto Md
(State or country)

10 NAME OF FATHER Stanley Majka

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Magdalen Cyhalevski

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

Informant (Address) Hospital Records

Filed 7-28 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27-30

17 I HEREBY CERTIFY, That I attended deceased from 7-26, 1930, to 7-27, 1930,

that I last saw her alive on 7-27, 1930,

and that death occurred, on the date stated above, at 7.40 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia Double

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia 24hrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Fuyko. M. D.

7/27, 1930 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery DATE OF BURIAL July 28 1930

20 UNDERTAKER George A. Weber ADDRESS 706 E Lanvale St

-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59231

CERTIFICATE OF DEATH

113

E 59231

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 837 Edmondson Ave. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thresa Reed

(a) RESIDENCE NO. 837 Edmondson Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: No.

6 DATE OF BIRTH (month, day and year): Oct 21 - 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	16	

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

8 BIRTHPLACE (city or town) (State or country): Baltimore Md

9 NAME OF FATHER: Chas Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Batalla Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Chas Brown

(Address): 837 Edmondson Ave

Filed 28 1930 192 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): July 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Florence Hedrick, M. D. Coroner

July 28 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel DATE OF BURIAL: 7/28 1930

20 UNDERTAKER: Henry Easton ADDRESS: 916 Penna Ave

ec.—1-30—M. & T.—250 Blks

E 59232 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59232

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

ITY OF BALTIMORE: (No. 4-25 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Mann

(a) RESIDENCE NO. 109 Pearl St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Martha

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sells coal and wood

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

BIRTHPLACE (city or town) (State or country) N. C.

10 NAME OF FATHER George Mann

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Charity ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records of

(Address) Balto. City Hosp.

Filed JUL 28 1930 H. MARION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26-30

17 I HEREBY CERTIFY, That I attended deceased from 6-28-28, 19..., to 7-26-30, 19...,

that I last saw h im alive on 7-26-30, 19...,

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) 2 yrs. mos da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

7-26-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 7-28-1930

20 UNDERTAKER Hurst Eastern ADDRESS 916 Broadway

-30—M. & T.—100 B—50L

E 59233

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59233

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) North Ave Street car (Ward) 15-67

2-FULL NAME Gustav V. Kaesemeyer.

(a) RESIDENCE NO 3831 Walbrook Ave. Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Germany.

7 AGE — Years: 70. Months: Days: If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

10 NAME OF FATHER: Fredk Kaesemeyer.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Lenhen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Charles F. Kaesemeyer

(Address) 36 Jason St. Hazleton

Filed 2-8 1930 192 H. BROOK JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ..... yrs. Sudden

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) July 25 1930 H. Bruck, M. D. Coroner

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: 7/28/1930

UNDERTAKER: H. C. Brenneman Son

ADDRESS: 1131 Pulton Ave

sec.—1-30—M. & T.—250 Blks

59234

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1930 E 59234

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 S. Linwood Ave. ST. 1-1 WARD)

2-FULL NAME Alonzo D. Hendley

(a) RESIDENCE NO. 909 S. Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Susie C. Hendley

DATE OF BIRTH (month, day, and year) April 4 1879

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	3	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Franklin Co. Va.

10 NAME OF FATHER Noah Hendley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cumberland, Md.

12 MAIDEN NAME OF MOTHER Vithian Hodges

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Franklin Co. Va.

Informant Susie C. Hendley

(Address) 909 S. Linwood Ave.

Filed 2-8 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1930

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1930, to July 26, 1930, that I last saw him alive on July 25, 1930, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Heat Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Joseph Toulon M. D.

, 19 (Address) 900 S. Edwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL July 28 1930

20 UNDERTAKER George W. Zickler

ADDRESS 1737 E. Eager st

Spec.—1-10-21—M&T—1500 Bks.

Mrs. Singley.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59235

CERTIFICATE OF DEATH.

E 59235

REGISTERED NO. 194

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. E. 209 Hoffman St. 12-19 WARD)

2-FULL NAME 209 Hoffman St Mrs. Singley

(a) RESIDENCE No. Mrs. Singley ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cornelius Singley

6b DATE OF BIRTH (month, day, and year): 1854

7 AGE: Years 76 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

(c) Name of employer: Mr. Kelly

9 BIRTHPLACE (city or town) (State or country): Balto. Co., Md.

PARENTS

10 NAME OF FATHER: William Singley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co.

12 MAIDEN NAME OF MOTHER: Lillie Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co.

14 Informant (Address): Mrs. Singley 209 Hoffman St

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1930 to July 26th 1930.

that I last saw h alive on July 24th 1930

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

3 Days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

(Address) 1700 Druid Park Drive

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cockeville md

DATE OF BURIAL: July 28 1930

20 UNDERTAKER: Joseph A Lucy

ADDRESS: 409 N Monroe St

ec.—1-12-23—M&T—500 Blks.

59236

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 59236

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 2050 Eastern Av ST., 2-4 WARD)

2-FULL NAME Josephine Majewska

(a) RESIDENCE No. 2050 Eastern Av ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Dec 22-29

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town)
(State or country) Baltimore

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) ?

12 MAIDEN NAME OF MOTHER Lora Majewski

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Pa

Informant Lora Majewski
(Address) 2050 Eastern Av.

Filed 8-1930. 19.. C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1930 to July 27, 1930, that I last saw h.. alive on July 27, 1930, and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Exacerbation of Chronic Intestinal Indigestion.
(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Acidosis
(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Emil Steingler M. D.

7-28, 1930 (Address) 1900 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 28 1930
UNDERTAKER J. H. Bazenek	ADDRESS 1930 Eastern Av

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59237

CERTIFICATE OF DEATH.

146 E 59237

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3009 E. Baltimore ST., 7-10 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Mabel Biebel

(a) RESIDENCE NO. 509 N. Lakewood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anthony Vincent Biebel

6 DATE OF BIRTH (month, day, and year): 1905

7 AGE — Years: 24 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Harry Dunlop

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Lillian Reifnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Anthony Biebel 509 N. Lakewood Ave

15 Filed 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25 1930

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to July 25, 1930, that I last saw h alive on July 25, 1930, and that death occurred, on the date stated above, at 6:12 P. m. (D.S.T.)

The CAUSE OF DEATH* was as follows:

Postpartum eclampsia

(duration) yrs. mos 15 hrs. ds.

CONTRIBUTORY (Secondary): Pulm. oedema

(duration) yrs. mos 3 hrs. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. data

(Signed) Kohnlenger, M. D.

. 19 (Address) 303 E. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem.

DATE OF BURIAL: 7/28/1930

20 UNDERTAKER: J. A. Moran

ADDRESS 300 E. Balto.

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 ✓

E 59238

REGISTERED NO. E 59238

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

ITY OF BALTIMORE: (No.) Sydenham Hospital ST. 11-24 WARD)

2—FULL NAME Catharine Harris

(a) RESIDENCE NO. 875 Linden Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
ema le	Black	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Feb. 17, 1926

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	5	10	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

IRTHPLACE (city or town) Baltimore,
State or country) Md.

10 NAME OF FATHER Paul Harris

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Rebecca Sherman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

Informant Rebecca Sherman Harris
(Address) 875 Linden Ave.

[illegible] JONES, M. D.
Registrar

28 1930. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1930, to July 27, 1930, that I last saw h[illegible] alive on July 27, 1930 and that death occurred, on the date stated above, at 10 55 A. m.

The CAUSE OF DEATH* was as follows:

1, Cerebral Hemmorhage
Cause unknown
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Examination of brain

(Signed) I. Peter Meranske, M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Albion

DATE OF BURIAL 7/28 1930

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pennsylvania ave.

...ec.—1-30—M. & T.—250 Blks.

23 9 140 E 59239

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 2 E 59239

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 16-26 WARD)

2-FULL NAME Esther Lyles

(a) RESIDENCE NO. 634 N. Carrollton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Child

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) June 7-1923

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	1	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Md —
(State or country)

10 NAME OF FATHER John Lyles

11 BIRTHPLACE OF FATHER (city or town) Md —
(State or country)

12 MAIDEN NAME OF MOTHER Latona Preston

13 BIRTHPLACE OF MOTHER (city or town) Md —
(State or country)

Informant Records —
(Address) JOHNS HOPKINS HOSPITAL

FILED 1 28 1930 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26-30

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 26, 1930,
that I last saw her alive on July 24, 1930,
and that death occurred, on the date stated above, at 8 35 a m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal fluid examination

(Signed) J. Bickford, M. D.

7/26 1930 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Grace Ind. DATE OF BURIAL July 28 1930

20 UNDERTAKER Wm. L. Beasley & Bro. ADDRESS 578

Rhoades

HEALTH DEPARTMENT—CITY OF BALTIMORE

59240

CERTIFICATE OF DEATH.

194 E 59240

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 76-1 WARD)

2-FULL NAME Edward Rhodes

(a) RESIDENCE NO. 1102 S. Bouldin St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Carrie Rhoades

6 DATE OF BIRTH (month, day, and year) Dec 12 1874

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer - Q40

(b) General nature of industry, business, or establishment in which employed (or employer) Copper Mill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Edward Rhoades

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Hospital Records

(Address)

Filed C. HAMILTON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24-30

17 I HEREBY CERTIFY, That I attended deceased from 7-23, 1930, to 7-24, 1930, that I last saw him alive on 7-24, 1930, and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Heat Exhaustion

(duration) yrs. mos 1½ ds.

CONTRIBUTORY (Secondary) Arteriosclerosis CVR

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? At work

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

7/24, 1930 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL July 28, 1930

20 UNDERTAKER John G Denny — ADDRESS 752 S. Eutaw St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 59241 — 129 E 59241

REGISTERED NO.

E 5924?

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Millman ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Bennett

(a) RESIDENCE NO. 1617 Millman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Willie Bennett.

DATE OF BIRTH (month, day, and year) Dec. 23, 1892?

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
37		7	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Major Bonds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mds.

12 MAIDEN NAME OF MOTHER Sophia Bonds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Mabel Brad[illegible] (Address) 1617 Millman St

Filed 2 8 1930, 19 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1929 to July 26, 1930, that I last saw h[illegible] alive on July 26, 1930, and that death occurred, on the date stated above, at 4:30 p m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) — yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Bhelompis, M. D.

, 19 (Address) 1134 Cawlmes St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodland M. Mayfield Inc — DATE OF BURIAL 7/29 30

UNDERTAKER [illegible] — ADDRESS 1515 M[illegible]

Dec.—1-30—M. & T.—250 Bks.

59242 HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 59242

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospitals ST. 19-26 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche M. Schwab

(a) RESIDENCE NO. 307 S. Parrish ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Schwab

DATE OF BIRTH (month, day, and year) October 10-1881

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	9	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER John Krumbine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Caine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant John H. Schwab.

(Address) 307 S. Parrish St.

Filed JUL 28 1930 HAMILTON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-25-30

17 I HEREBY CERTIFY, That I attended deceased from 7-21-30, 19..., to 7-25, 1930

that I last saw h[illegible] alive on 7-25, 1930,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoid

(duration) yrs. 3 mos 7 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Luther E. Tiode, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery. DATE OF BURIAL July-29 1930.

20 UNDERTAKER Charles J. Schwab. ADDRESS 505 N. Monroe St.

ec.—1-30—M. & T.—250 Blks

59243 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59243

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals

ITY OF BALTIMORE: (No. 7231 ST. (OR WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Pulley

(a) RESIDENCE NO. 712 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Emma B.

DATE OF BIRTH (month, day, and year) Nov. 20, 1888

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
41	42	8	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Jake Pulley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Virtue James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Records of

(Address) Balto. City Hosp.

Filed JUL 28 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-25-30

17 I HEREBY CERTIFY, That I attended deceased from 6-6-30, 19..., to 7-25-30, 19...,

that I last saw him alive on 7-25-30, 19...,

and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocaydtis, chronic and acute

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Hypertension. UNKNOWN.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Paul Podgt, M. D.

7-26, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL July 29 1930

20 UNDERTAKER S. L. Brown & Son

ADDRESS 101 W. Mount

ec.—1-30—M. & T.—250 Blks.

59244

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x74002

E 59244

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH (a) University Hospital
ITY OF BALTIMORE (No. Lombard and Greene ST. 4-30 WARD)

2-FULL NAME Robert Shorter

(a) RESIDENCE NO. Odenton, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Feb. 1 1915

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5 yrs	5	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer — yo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Odenton Md

10 NAME OF FATHER Robert Shorter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Jane Smith
(Address) Odenton Md

JUL 28 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to July 27, 1930, that I last saw him alive on July 27, 1930, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Sinus Pyriformis

(duration) yrs. mos 2 1 da.

CONTRIBUTORY (Secondary) Meningitis

(duration) yrs. mos. 7 ds.

15 Where was disease contracted if not at place of death? Odenton,

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) W. H. Varney M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fork Church A & Co Md — DATE OF BURIAL July 28 1930

20 UNDERTAKER M. [illegible] Sons — ADDRESS Bowie Md

Joseph Kirssin

59245 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. + 57 E 59245

REGISTERED NO.

1-PLACE OF DEATH Baltimore, Maryland

CITY OF BALTIMORE: (NO. Sinai Hospital ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Joseph Kirssin

(a) RESIDENCE NO. Sinai Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Mollie

6 DATE OF BIRTH (month, day, and year) Oct 15 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Levy Kirssin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rosell U.K.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Mrs Mollie Kirssin

(Address) Shippensburg Pa

Filed JUL 28 1930 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 26, 1930

that I last saw him alive on July 26, 1930

and that death occurred, on the date stated above, at 9:00 A. m.

The CAUSE OF DEATH* was as follows:

Bilateral Pneumonia 1. Bilateral Pneumonia - asthenia 1. Cardiac death.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Toxemia - diabetes

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Shippensburg Pa.

Did an operation precede death? No Date of July 26/30

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic Examination

(Signed) Meyer M. Boyden M. D.

July 26 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cemetery DATE OF BURIAL July 28 1930

20 UNDERTAKER L. Levinson Bro ADDRESS 1127 E Balto St

ec.—1-30—M. & T.—250 Blks

59246 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59246

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 846 W. Fayette ST. 18-26 WARD)

2-FULL NAME Charles H. Heldmann

(a) RESIDENCE NO. 846 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) July 20 1862

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	7	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

BIRTHPLACE (city or town) Baltimore Md.
(State or country)

10 NAME OF FATHER Henry Heldmann

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

Informant George H. Heldmann

(Address) 846 W. Fayette

Filed ... 1930 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26-1930

17 I HEREBY CERTIFY, That I attended deceased from July 9-, 1930, to July 26-, 1930, that I last saw him alive on 7-24-, 1930, and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

acute Parenchymatous Nephritis

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) Chester Ruland, M. D.

7-26 1930 (Address) 2532 Edmondson.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	7/28 1930
UNDERTAKER	ADDRESS
Frederick A. Cole	1200 Wilmot Rd

HAMPTON JONES, M.

...c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46

E 59247

CERTIFICATE OF DEATH

E 59247

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Womens Hospital ST., 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edith Cushing Marshall.

(a) RESIDENCE NO. 32 W. Biddle. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 9 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white.	married

If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Marshall.

DATE OF BIRTH (month, day, and year) Oct 11 - 1873.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	9	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

NAME OF FATHER John Cushing Jr.

BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

MAIDEN NAME OF MOTHER Annette Whiteland

BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

Informant. John W. Marshall.

(Address) 32 W Biddle St

Filed JUL 28 1930 H. McKOWN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1930, to July 28, 1930, that I last saw her alive on July 28, 1930 and that death occurred, on the date stated above, at 3 15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus - & metastases to bladder. I

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydronephrosis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Not immediate

Did an operation precede death? Date of Dec. 1928

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Edwin F. Hardyce, M. D.

7/28, 1930 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL July 29 1930

20 UNDERTAKER Henry Wenkins & Son

ADDRESS Oakland Pre Catholic St

sec.—1-30—M. & T.—250 Bks.

35576 E 59248

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 59248

CERTIFICATE OF DEATH.

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST. 26-40 WARD .....

2-FULL NAME Mary McDermott

(a) RESIDENCE NO. 3017 Mayfield Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of George W. McDermott

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Patrick Foley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Ernest

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Records (Address) JOHNS HOPKINS HOSPITAL

Filed 2 8 1930 NAME JOHN M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26-1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to July 26, 1930, that I last saw h[illegible] alive on July 26, 1930, and that death occurred, on the date stated above, at 5-20 p m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) yrs. 3 mos. 26 ds.

CONTRIBUTORY (Secondary) diabetic Gangrene

(duration) yrs. 1 mos. 28 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of May 29

Was there an autopsy? no

What test confirmed diagnosis? Blood Sugar determ.

(Signed) I. Ridgway Trumbk M. D.

(Address) July 26/1930 Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL July 29 1930

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS Baltimore St & Broadway.

sec.—2-29-28—L. F. 5 Martha A. Burkins

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59249

CERTIFICATE OF DEATH

47 ✓ E 59249

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 811 S. East Ave. St. 76-1 WARD)

2—FULL NAME MARTHA A. BURKINS

(a) RESIDENCE NO. 811 S. East Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred Lifse mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of - - -

ATE OF BIRTH (month, day, and year) August 23, 1881

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	11	4	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Baltimore (State or country)

0 NAME OF FATHER John F. Burkins

1 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

2 MAIDEN NAME OF MOTHER Susie A. Carroll

3 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

Informant Mrs. John F. Burkins (mother)

(Address) 811 S. East Ave.

Filed 7/28, 1930 C. HAMPSON JONES, M. D. Registrar

28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to July 26, 1930, that I last saw h a alive on July 26, 1930. and that death occurred, on the date stated above, at 8.55 a.m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma

(duration) 4½ yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of 1926

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Henry B. Fahey, M. D.

7/28, 1930 (Address) 2504 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL July 29, 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore St. & Broadway.

...ec.—1-30—M. & T.—250 Bks

59250

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23 E 59250

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 Brentwood ST 10-15 WARD)

2-FULL NAME Joseph John Murnane

(a) RESIDENCE NO. 1024 Brentwood WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Clara M. Kearns

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secy

(b) General nature of industry, business, or establishment in which employed (or employer) Dedicated Inc.

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER John F. Murnane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire.

12 MAIDEN NAME OF MOTHER Honora M. Enright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire

Informant Mrs. Clara M. Murnane

(Address) 1024 Brentwood Ave

Filed 8-1930 C. H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 / 30.

17 I HEREBY CERTIFY, That I attended deceased from March 5, 30 to July ..., 19 30

that I last saw h... alive on July 25 / 30

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows: Encephalitis Lethargica

(duration) yrs. 4 mos ... ds.

CONTRIBUTORY (Secondary) Heart

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) T. Wedderburn M. D.

(Address) 600 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 7/29 1930

20 UNDERTAKER Rita Maedefield

ADDRESS 409 Greenmount Ave

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 59251

CERTIFICATE OF DEATH

59251

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO. 7766 J

CITY OF BALTIMORE: (No. Fayette + Calhoun ST., 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Rhoda Fall

(a) RESIDENCE NO. 1826 W Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

10 NAME OF FATHER: John Bryson

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER: Jane Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Y.

Informant: Mrs. Mary Stephens

(Address) 1826 W. Lombard St.

Filed 2-8 1930, 19 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27-30

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 27, 1930, that I last saw her alive on July 27, 1930 and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardio Vascular Renal disease (duration) 3 yrs. mos. ds.

Senile decompensation

18 Where was disease contracted if not at place of death? Franklin Square Hospital

Cerebral Hemorrhage

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Paralysis

(Signed) B. B. Schreiber, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Mount Olivet Cemetery — DATE OF BURIAL: June 29 1930

20 UNDERTAKER: George L. Johnson — ADDRESS: 1211 Eutaw St.

Spec.—1-10-21—M&T—1500 Blks.

59252

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 59252

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 S. Payson ST. 20-28 WARD)

2-FULL NAME Caroline Stolle

(a) RESIDENCE NO. 208 S. Payson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Cole

6 DATE OF BIRTH (month, day, and year) Nov. 23-1848

7 AGE — Years: 81 — Months: 8 — Days: 7 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) Catonville (State or country) Md

PARENTS

10 NAME OF FATHER Adam Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Kolb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. H. E. Beasley (Address) 208 S. Payson St.

15 Filed JUL 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1930

17 I HEREBY CERTIFY, That I attended deceased from July 19 1930 to July 26 1930, that I last saw h alive on July 25 1930 and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Cb. Nephritis.

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Beyd M. Cairns, M. D.

7/27/1930 (Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: July 28 1930

20 UNDERTAKER: George L. Schwab — ADDRESS: 2101 Pulaski St.

...—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59253 E. Ross. Williar

CERTIFICATE OF DEATH

E 59253

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No. Maryland General Hosp. ST. Rm 219 WARD)

2—FULL NAME Mr. Edward D. Williar

(a) RESIDENCE NO. 1202 E. Federal ST., WARD Baltimore Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 1 ds. How long in U. S., if foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

6 If married, widowed or divorced HUSBAND of (or) WIFE of Mrs Anna Williar

7 DATE OF BIRTH (month, day, and year) Aug 26 1862

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67.	11	1.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) State or country) Baltimore, Md

10 NAME OF FATHER Andrew Williar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary A. Bizzard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Hospital records

(Address)

C. HAMILTON JONES, M. D. Registrar

JUL 31 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27/30

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1930, to July 27, 1930, that I last saw h.im alive on July 27, 1930, and that death occurred, on the date stated above, at 11:25 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Carcinoma Pylorus

7 7

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 7-15-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert K. Cleveritz, M. D.

(Address) Md. General Hospital

7/27, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL July 30 1930

20 UNDERTAKER Henry Hoen Sons Inc.

ADDRESS 130 E Eager St

59254

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 59254

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat S 2863 WARD)

2-FULL NAME Catherine Manning

(a) RESIDENCE NO. Mt Hope Retreat ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	Unknown		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

BIRTHPLACE (city or town) Unknown
(State or country) Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown

Informant Mt Hope Retreat
(Address) Mt Hope Retreat

Filed JUL 28 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28. 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1925, to July 28, 1930.

that I last saw her alive on July 26, 1930,

and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Paresis.
Syphilis (Cerebral)

Unknown Over (duration) 6 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Milton P. Free, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery DATE OF BURIAL July 29 19 30

UNDERTAKER Edward Arnold ADDRESS Balto

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59255

CERTIFICATE OF DEATH.

1942

E 59255

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave St. 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Julia A. Smith.

(a) RESIDENCE NO. Home for the Aged of the M.E. Church St.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Baltimore yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 10 1846

7 AGE: Years 84 | Months 2 | Days 17 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore City Md.

(State or country)

PARENTS

10 NAME OF FATHER Robert F. Smith.

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary E. Reamer

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Baltimore Md

14 Informant Mary B. Lapp

(Address) 400 Fulton Ave Balto Md

Filed 2-8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27-1930

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1930, to July 27, 1930; that I last saw h.er alive on July 25, 1930, and that death occurred, on the date stated above, at 2.45 a m.

The CAUSE OF DEATH* was as follows:

Chronic Arteritis

(duration) 4 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Heat Prostration

(duration) ✓ yrs. ✓ mos. 2 ds.

18 Where was disease contracted ✓

If not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) George L. Shannon, M. D.

7-27-1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: July 29 1930

20 UNDERTAKER: George J. Smith — ADDRESS 1532 Hollins

Spec.—12-9-25—A Co.—200 Blks.

E 59256

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 59256

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave Ward 20-17

2-FULL NAME Miss Henrietta N. Shipley.

(a) RESIDENCE NO. Home for the Aged of the M.E. Church

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ✓ mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 17-1842

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	88	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Howard County Md.

PARENTS

10 NAME OF FATHER Talbott Shipley.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Sarah Warfield

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Howard Co. Md

14 Informant Ella Cuddy

(Address) 400 N. Fulton Ave

Filed JUL 29 1930 HAMPSON JONES, M. D. Registrar

2 8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1930

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1930, to July 28, 1930, that I last saw h.e alive on July 27, 1930, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 5 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Heat Prostration

(duration) ✓ yrs. ✓ mos. 3 ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Methods

(Signed) George C. Pleasants, M. D.

7/28. 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Vicentium Date of Burial July 29 1930

20 UNDERTAKER George J. Smith ADDRESS Baltimore

ec.—1-30—M. & T.—250 Bks

E 59257 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 2923 Hinchester St. (WARD) 46-67

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter A Ennor

(a) RESIDENCE NO. 2923 Hinchester St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced
HUSBAND of (or) WIFE of Gertrude Ennor

DATE OF BIRTH (month, day, and year) Oct 29/1860

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	8	29	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Reporter for 086
(b) General nature of industry, business, or establishment in which employed (or employer) Bradstreets
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Richmond Va

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Elsie R. Hyles
(Address) 2923 Hinchester St.

Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28/30

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1930, to July 28, 1930.
That I last saw him alive on July 27th, 1930,
and that death occurred, on the date stated above, at 1330 A m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Paralysis Agitans

(duration) 8 yrs. — mos. — ds.

18 Where was disease contracted, if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Robert L Chambers, M. D.
19 (Address) 530 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	July 30 1930
20 UNDERTAKER Harry H Simmons	ADDRESS 4204 Ridgewood Ave

-30—M. & T.—100 B—50L

E 59258

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59258

CERTIFICATE OF DEATH

+ 199

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hosp ST. 25-72 WARD)

2-FULL NAME Alexander Goldner

(a) RESIDENCE NO 7000 McCallum St., Phila Pa WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 1 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Sydie Goldner

DATE OF BIRTH (month, day, and year) Aust Russ

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Auto
(b) General nature of industry, business, or establishment in which employed (or employer) Dealer
(c) Name of employer self

BIRTHPLACE (city or town) (State or country) Phila Pa

10 NAME OF FATHER Simon Goldner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia Phila Pa

12 MAIDEN NAME OF MOTHER Bertha Wenn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Aust Russ

Informant Sarah Cole 720 Rockland
(Address) Glenside Pa

Filed 8 1930, 192 E. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Auto in which he was driving Collided with Truck

(a) ..... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Thrombosis - Fracture of Left Femur (Duration) ... ds.

18 Where was disease contracted if not at place of death? Elkridge Md

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Frame, M. D. Coroner

7/28, 1930 Address 529 3 Ave Elkridge

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa — DATE OF BURIAL 7/28/30

20 UNDERTAKER Johnsons & Co — ADDRESS 243 Darby Road

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59259 | E 59259

CERTIFICATE OF DEATH.

61-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 866 Pine ST. 18-26 WARD)

2-FULL NAME Baby Girl Colbert

(a) RESIDENCE NO. 866 Pine ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: B | 5 Single, Married, Widowed, or Divorced. (write the word): single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) 7/27/30

AGE: Years ..... Months ..... Days 7/27/30 | If LESS than 1 day, 6 hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt. Md
(State or country)

PARENTS

10 NAME OF FATHER Theodore Harris

11 BIRTHPLACE OF FATHER (city or town) Nash
(State or country) Chester. Md

12 MAIDEN NAME OF MOTHER Helen Colbert 7/28. 19 30

13 BIRTHPLACE OF MOTHER (city or town) Annapolis
(State or country)

14 Informant Helen Colbert
(Address) 866 Pine St

15 8 1930 ..... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27/30 19

17 I HEREBY CERTIFY, That I attended deceased from 7/27/30, 19 ..... to 7/27/30, 19 .....

that I last saw h alive on 7/27/30, 19 .....

and that death occurred, on the date stated above, at 12 ..... m.

The CAUSE OF DEATH* was as follows:

Premature birth
(26 wks)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Lud H Rogers M. D.

(Address) Mat. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS JUL 28 1930

Par Wm. S. WOGRAL

ec.—1-30—M. & T.—250 Blks.

E 59260 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59260

CERTIFICATE OF DEATH.

REGISTERED NO. 161-901

1-PLACE OF DEATH

ITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST. 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hutchins

(a) RESIDENCE NO. 1924 Henneman Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	—

If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	2 hrs. 55 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) Balto

(State or country) Maryland

10 NAME OF FATHER Hutchins

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Irene Hutchins

13 BIRTHPLACE OF MOTHER (city or town) Maryland

(State or country)

Informant C. H. Douglas

(Address) Johns Hopkins Hospital.

C. HARRISON JONES, M. D.

Registrar

JUN 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15th 1930

17 I HEREBY CERTIFY, That I attended deceased from 6-15-, 1930, to 6-15-, 1930,

that I last saw him alive on 6-15-, 1930,

and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. H. Douglas, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JUL 2 8 1930 19

UNDERTAKER Commissioner Health

ADDRESS

sec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 59261

E 59261

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 1804 Clifton Ave. ST 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Snyder,

(a) RESIDENCE NO. 1804 Clifton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Married

If married, widowed, or divorced (6) HUSBAND of (or) WIFE of Harry Snyder

ATE OF BIRTH (month, day, and year) May 19.1882

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	48	2	7	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Baltimore Md.

0 NAME OF FATHER Charles Engelbach,

1 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

2 MAIDEN NAME OF MOTHER Wilhelmina Hagerdorn

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

Informant Charles Engelbach

(Address) 1804 Clifton Ave

Filed 8 1930 C. HAMILTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUL 26 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-24, 1930, to 7-26, 1930, that I last saw her alive on 7/26, 1930 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Wm J Burns, M. D.

7/27, 1930 (Address) 1920 Eutaw Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine

DATE OF BURIAL JUL 29 1930

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE

...ec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59262 ✓ E 59262

CERTIFICATE OF DEATH

90

REGISTERED NO. 16-69

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 Glenwilden Ave ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Thomas Maxwell.

(a) RESIDENCE NO. 617 Glenwilden Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

If married, widowed, or divorced HUSBAND of (or) WIFE of: Elsie T. Maxwell.

DATE OF BIRTH (month, day, and year): Jan 1870

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Keeper of Store

(b) General nature of industry, business, or establishment in which employed (or employer): Grocery Store

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Seaford Del.

10 NAME OF FATHER: Perry Maxwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Del

12 MAIDEN NAME OF MOTHER: Mary Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Del

Informant: Elsie T. Maxwell.

(Address): 617 Glenwilden Ave.

Filed 1930 — C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27-1930.

17 I HEREBY CERTIFY, That I attended deceased from July 15- 1930, to July 27- 1930, that I last saw h.. alive on July 25- 1930 and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyelitis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs & urinalysis

(Signed) Chester Ruland, M. D.

7-27-1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: JUL 30 1930

20 UNDERTAKER: Geo W Little

ADDRESS 2700 EDMONDSON AVE.

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

194 E 59263

CERTIFICATE OF DEATH

59263

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Whatcoat St. 16-22 WARD

2-FULL NAME Ernestine Reed

(a) RESIDENCE NO 906 Whatcoat St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 7 mos. 6 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) June 7-1880

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	7	6	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Bethel Ga

10 NAME OF FATHER Robt Green Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant S. W. Chase

(Address) 1400 Mosher

C. HAMPSON JONES, M. D. Registrar

1930 July 192 at 11

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Prostration

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible], M. D. Coroner

July 29 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL July 29, 1930

20 UNDERTAKER Samuel W. Chase

ADDRESS 1400 Mosher

Spec.—1-10-21—M&T—1500 Blks.

E 59264

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 59264

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sieling Sanitarium ST. 14-20 (WARD)

2-FULL NAME Alice McShane

(a) RESIDENCE NO. 1403 John ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 80 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Charles McShane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Boyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Mary C. Burrows

(Address) 1403 John Street

Filed 8 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1930

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to July 28, 1930, that I last saw her alive on July 28, 1930, and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Enteritis - acute -

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) C. H. Jones, M. D.

7/8, 1930 (Address) Catonsville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Cemetery, Govans — DATE OF BURIAL: 7/31 1930

20 UNDERTAKER: Henry U. Mears & Son — ADDRESS: 805 N. Calvert

ec.—1-12-23—M&T—500 Blks.

E 59265

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59265

CERTIFICATE OF DEATH

REGISTERED NO. 40

1-PLACE OF DEATH Hopkins Memorial Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1000 Eaton Ave ST. 11 WARD 15)

2-FULL NAME Francis H. D. Mason

(a) RESIDENCE NO. 803 North Calvert WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER John T. Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country): Alexandria Va

12 MAIDEN NAME OF MOTHER Ada Hewitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Hopkins Memorial Hosp

(Address) Place Eaton Ave

HAMPSON JONES, M. D.

Registrar

8 1930 , 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1930

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1930, to July 27, 1930, that I last saw him alive on July 26, 1930, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis with decompensation

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No Clinical findings

What test confirmed diagnosis?

(Signed) Hjalmar S. Anderson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery

DATE OF BURIAL: 7/29 1930

20 UNDERTAKER: Henry A. Mears & Son

ADDRESS 805 N. Calvert

c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 59266

59266

CERTIFICATE OF DEATH

REGISTERED NO. 27-56

1—PLACE OF DEATH Maryland General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. Madison & Lyndenc ST. (If not in hospital)

2—FULL NAME Mrs. Emma Borneman

(a) RESIDENCE NO. 4908 Cordelia Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) June 29, 1895

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	1	29	

CUPATION OF DECEASED

) Trade, profession or particular kind of work Housewife 037

) General nature of industry, business, or establishment in which employed (or employer)

) Name of employer

RTHPLACE (city or town) Baltimore
State or country) Md

0 NAME OF FATHER Jefferson D. Rotin

1 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

2 MAIDEN NAME OF MOTHER Rena Lloyd

3 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

Informant Mrs. R Low
(Address) 4908 Cordelia Av

Filed ..., 19... HAMPSON JONES, M. D.
Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28-30

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1930, to July 28, 1930.

that I last saw her alive on July 28, 1930

and that death occurred, on the date stated above, at 7:25a m.

The CAUSE OF DEATH* was as follows: Cancer of Rt Lung with metastasis to pleura ?

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage into pleural cavity (left) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 8/10/29 10/24/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert W. Cromwell, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL July 30 19 30

20 UNDERTAKER Wm. H. Marshall ADDRESS 253 Fall Rd

Spec.—1-12-23—M&T—500 Blks.

E 59267. HEALTH DEPARTMENT—CITY OF BALTIMORE 001 E 59267

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3109 Glendale Ave (ST.) 27-43 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Robt. P.C. Scheidt

(a) RESIDENCE NO. 3109 Glendale ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Annie Scheidt

DATE OF BIRTH (month, day, and year) Aug-17-1859

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	11.-	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Jacob Scheidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER — Volkmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. Paul Douglas

(Address) 3109 Glendale Ave

1930 ... 19 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-28 1930

17 I HEREBY CERTIFY, That I attended deceased from June- ..., 1928, to July-28, 1930,

that I last saw him alive on July 28, 1930

and that death occurred, on the date stated above, at 12:15 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis complicated with apoplexy about 2 yrs ago. Myocarditis. Senile. Acute heart failure (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Gradual cerebral degeneration (duration) — 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Wesley Cole M. D.

7/28 1930 (Address) 2202 Harrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairmount Cemetery	July 30 30
UNDERTAKER	ADDRESS
H S Marshall	3539 Fall Road

C.—1-30—M. & T.—250 Blks.

59268

HEALTH DEPARTMENT—CITY OF BALTIMORE E 59268

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals S. 16-22 (WARD)

REGISTERED NO. 100001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.)

2-FULL NAME Lana Hopkins

(a) RESIDENCE No. 1137 N Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 1858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) — (State or country) Anne Arundel County Md.

10 NAME OF FATHER Zack Dotson

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

Informant Records Dept Baltimore City Hospitals (Address)

C. HAMPSON JONES, M. D. Registrar

1930 19 PAT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27-30

17 I HEREBY CERTIFY, That I attended deceased from 7-14, 1930, to 7-27, 1930, that I last saw h[illegible] alive on 7-27, 1930, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Simulgid arteriosclerosis Uterine fibroid with degeneration

(duration) unknown yrs. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy findings

(Signed) Fred M. Dudenhefer, M. D.

19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL July 30 1930

UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59269

CERTIFICATE OF DEATH

113

E 59269

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1142 Woodyear St. 6-23 (WARD)

2-FULL NAME Charles Bradford

(a) RESIDENCE No. 1142 Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of None

DATE OF BIRTH (month, day, and year) Jan 28 1929

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	—	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Malcolm Bradford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mabel Franklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mabel Bradford

(Address) 1142 Woodyear

Filed July 29, 1930 C. HAMPSON JONES, M. D. Registrar

81330

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 28th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Polk, M. D. Coroner

July 29, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL July 29 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59270

CERTIFICATE OF DEATH

198 E 59270

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced at

City of Baltimore: (No. Balto City Hos St. 14-59 Ward)

2-FULL NAME Robert Smith Turner

(a) RESIDENCE NO. 2102 Division St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 21 1907

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	22	10	5 6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

10 NAME OF FATHER Geo. R. Turner

11 BIRTHPLACE OF FATHER (city or town) Charles
(State or country) Md

12 MAIDEN NAME OF MOTHER Carrie Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto City
(State or country)

14 Informant Geo R. Turner
(Address) 2102 Division

15 Filed ..., 19.. C. HAMPSON JONES M.D. Registrar
7 28 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to His death on the day stated above.

The CAUSE OF DEATH* was as follows:
Stab Wound with Pocket Knife severing Lt Subclavian Vein, Manslaughter?
(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Hemorrhage
(duration) ..yrs. few minutes mos.

18 Where was disease contracted if not at place of death? Shot Balto Co.,
Did an operation precede death? No Date of
Was there an autopsy? Yes Clinical Results
What test confirmed diagnosis?
(Signed) James H Henderson, M. D.
7 28 1930 (Address) 7001 Chas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 30 1930
20 UNDERTAKER Thomas E. Kelson	ADDRESS 3303 Presstman St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59271

CERTIFICATE OF DEATH

182 E 59271

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH: Found floating off Broening Park. 2-4

City of Baltimore: (No.) St. (Ward)

2-FULL NAME: John J. Kavenaugh.

(a) RESIDENCE NO. 1819 E. Pratt St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) June 15, 1900

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	30	1	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Elevator operator
(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R. Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co. Md.
(State or country)

10 NAME OF FATHER Stephen P. Kavenaugh.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Co. Md.

12 MAIDEN NAME OF MOTHER Cecelia Bauer.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Co. Md.

14 Informant Stephen P. Kavenaugh. (father)
(Address) 1819 E. Pratt St.

15 Filed ..., 19... C. HARPSON JONES M. D. Registrar
1930 By ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1930 found July 26, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to h/s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Occidental Drowning while crabbing.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible], M. D.

7/28. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: 7/29 1930

20 UNDERTAKER: William Cook

ADDRESS: 12 N. St. Paul St.

Dr Elbourn Cook Ave

c.—1-30—M. & T.—250 Blks.

E 59272 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59272

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3212 Haywood Ave (WARD) 27-55

2-FULL NAME Elizabeth Roy Bailey

(a) RESIDENCE NO. 3212 Haywood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of: Hiram H Bailey

DATE OF BIRTH (month, day, and year): May 30, 1865

AGE: Years 65 | Months 3 | Days 28 | If LESS than 1 day, ...hrs. or ...min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Home

BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

Informant (Address): Russell S Bailey 3212 Haywood Ave

C. HAMPSON JONES, M. D. Registrar

1930 ..... 19 .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1930

July, 1928, to July 27, 1930

that I last saw him alive on July 27, 1930

and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Organic Intestinal Stricture

(duration) 2 yrs. (mos ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Irvine Elbourn, M. D.

19 28 (Address) 700 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

20 UNDERTAKER: Fink

DATE OF BURIAL: 7/31/1930

ADDRESS: 1217 E Lombard

Dr Gordon, North Gay & Fayette Sts

c.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59273

CERTIFICATE OF DEATH.

REGISTERED NO. 59273

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1113 N Milton Ave (St.) (Ward) 8-12

2-FULL NAME Sylvia G Eder

(a) RESIDENCE NO. 1113 N Milton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of or) WIFE of: Charles Eder

DATE OF BIRTH (month, day, and year): March 28 1870

AGE: Years 60 Months 3 Days 29 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: at Home

BIRTHPLACE (City or town) (State or country): Baltimore Md

10 NAME OF FATHER: Thomas Edelmon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Amelia Rappley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

Informant: Charles Eder

(Address) 1113 N Milton Ave

C. HAMPSON JONES, M. D. Registrar

8-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-31-1930 to 7-27-1930, that I last saw h[illegible] alive on 7-27-1930, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Chronic myocarditis

(duration) yrs. 6 mos 27 ds.

CONTRIBUTORY (Secondary) anaemia -

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Georgia Gordon, M. D.

7-29-1930 (Address) 1211 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: 7/30 1930

20 UNDERTAKER: W M Cook

ADDRESS: 1217 E North Ave

c.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59274 | CERTIFICATE OF DEATH | 194 E. 59274

REGISTERED NO.

1—PLACE OF DEATH

TY OF BALTIMORE: (No. 1625 Shelton ST. 4-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura C. Wilson

(a) RESIDENCE NO. 1625 C Shelton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 75 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widow

married, widowed, or divorced HUSBAND of (or) WIFE of Henry C. Wilson

TE OF BIRTH (month, day and year) Jan. 1-1855

E	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	75	6	26	

CUPATION OF DECEASED

) Trade, profession or rticuiar kind of work At Home

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) tate or country) Balto. Md

NAME OF FATHER Henry C. Wilson

BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

MAIDEN NAME OF MOTHER Mary Fowler

BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant August Laun

(Address) 1625 C Shelton st

Registrar

8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27-30

17 I HEREBY CERTIFY, That I attended deceased from July 26-, 1930, to July 27, 1930

that I last saw h~~e~~r alive on July 27-, 1930

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma - Heat & Exhaustion (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Frank Brunel, M. D.

, 19 (Address) 125 W Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill — DATE OF BURIAL July 29, 30

UNDERTAKER William G. Schaefer — ADDRESS 1816 Monument

G. HAMPSON JONES, M.

c.—1-30—M. & T.—250 Bks.

E 59275 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59275

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital 5-55 32

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Irvin

(a) RESIDENCE NO. 2414 Steel ST., Rd. WARD City
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) April 10th 1925

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	3	17	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ...
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer ...

BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER William M Irvin

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Marjorie M Scott

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co.
(State or country) Md.

Informant (Father) William M Irvin
(Address) 2414 Steel Road

... THOMPSON ... M. D.

Filed ... 1930 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 18th, 1930 to July 27, 1930, that I last saw him alive on July 27, 1930, and that death occurred, on the date stated above, at 8:50 P. m.

The CAUSE OF DEATH* was as follows:
Tuberculous Meningitis

(duration) ... yrs. ... mos. 16 ds.

CONTRIBUTORY (Secondary) Suppurative otitis media (duration) 16 yrs. ... mos. 16 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal puncture

(Signed) L. G. Tyson M. D.

..., 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL July 29, 1930

20 UNDERTAKER Elmer M. Conkelein — ADDRESS 924 E. Eager St.

...c.—1-30—M. & T.—250 Bks.

59276 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59276

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 924 E Eager (Ward) 10-14

2-FULL NAME Elmer W. Conklin Jr.

(a) RESIDENCE NO. 924 E Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

REGISTERED NO. 194

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Jan. 28, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER Elmer W. Conklin Sr.

11 BIRTHPLACE OF FATHER (city or town) Baltimore Co Md (State or country)

12 MAIDEN NAME OF MOTHER Ellen M. Freshwater

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or country)

Informant Elmer W. Conklin Father (Address) 924 E Eager St

Filed 8 1930 19 C. THAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to July 28, 1930, that I last saw him alive on July 28, 1930, and that death occurred, on the date stated above, at 7:40 a m.

The CAUSE OF DEATH* was as follows:

Heat Exhaustion 7 hours.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Meningismus. (duration) yrs. mos. 7 hours ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Thomasin, M. D.

7/28 1930 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 7/31 1930

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS Baltimore St & Broadway.

...—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 59277

E 59277

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE; (No.) Md. General Hospital ST., 20-27 WARD)

2—FULL NAME L. Hicks Downes

(a) RESIDENCE NO. 1839 W. Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Single

married, widowed, or divorced
HUSBAND of
(or) WIFE of —

TE OF BIRTH (month, day, and year) Aug. 30, 1863

E	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	10	26	

CUPATION OF DECEASED

) Trade, profession or rticuiar kind of work Merchant

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) State or country) Maryland

NAME OF FATHER W. H. Downs.

BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

MAIDEN NAME OF MOTHER Elizabeth Willham

BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Mr. John H. Downes

(Address) 24 E. Pratt St.

C. HAMPSON JONES, M. D.

19 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1930.

17 I HEREBY CERTIFY, That I attended deceased from 7-16-1930, 19..., to 7-26—, 1930, that I last saw him alive on 7-26—, 1930 and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical test

(Signed) Robert Chesnutt, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ferndale, Md.	July 29, 1930
20 UNDERTAKER John O. Mitchell & Sons	ADDRESS 1900 Eutaw St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59278

E 59278

CERTIFICATE OF DEATH

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph's Hospital 1917 Ward)

2-FULL NAME Charles E. Malone

(a) RESIDENCE NO. 1429 E Federal St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lorraine M. Malone

6 DATE OF BIRTH (month, day, and year) March 1 1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41	4	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Paver
(b) General nature of industry, business, or establishment in which employed (or employer) Street
(c) Name of employer City of Balto

9 BIRTHPLACE (city or town)
(State or country) Pittsburg Pa

PARENTS

10 NAME OF FATHER Samuel Malone

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pittsburg

12 MAIDEN NAME OF MOTHER Ida Mason

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Lorraine Malone
(Address) 1429 E Federal St

Filed 8 1930 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broken Compensation

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Were findings considered in determining cause of death?

(Signed) H. G. Slade, M. D.

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	7/29 1930
20 UNDERTAKER William Cook	ADDRESS 1215 Park

ec.—1-30—M. & T.—250 Bks. Carmela Rossi

E 59279 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59279

CERTIFICATE OF DEATH.

65-001

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 229 S. Grundy ST. 26-27 WARD)
Car

2-FULL NAME Carmela Rossi
229 S. Grundy

(a) RESIDENCE NO..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) May 16 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	14	2	9 10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Antonio Rossi

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country) Filomena

12 MAIDEN NAME OF MOTHER Giannina

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

Informant Antonio Rossi
(Address) 229 S. Grundy St

FILED 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929 to July 26, 1930, that I last saw h alive on July 26, 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Leukemia

Cardio vascular failure

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical -

(Signed) Frank D. Paula, M. D.

, 19 (Address) 1325 W. Fall ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem.

DATE OF BURIAL 7/29/1930

UNDERTAKER George J. Puttee

ADDRESS 1735 Hanford Ave

—M. & T.—100 B—50L

E 59230

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185

E 59280

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) Franklin Sq Hosp ST. 18-21a (WARD)

2-FULL NAME James Claytburn Jr

(a) RESIDENCE NO. 407 N. Carrollton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Col	Single

married, widowed, or divorced
HUSBAND) of
(or) WIFE of

TE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	—	—	

CUPATION OF DECEASED
a) Trade, profession or articular kind of work none
b) General nature of industry, usiness, or establishment in hich employed (or employer)
c) Name of employer

RTHPLACE (city or town) Md
State or country)

NAME OF FATHER James Claytburn

BIRTHPLACE OF FATHER (city or town) S. C
(State or country)

MAIDEN NAME OF MOTHER Jessie Flynn

BIRTHPLACE OF MOTHER (city or town) N. C
(State or country)

ermant James Claytburn
(Address) 407 N. Carrollton

7-1930 Dr HAROLD JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental - Fell from third story window
Compound fracture of skull
(duration) yrs. mos da.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Smith, M. D.
Coroner
7/28, 1930 (Address) 3601 Third St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary — DATE OF BURIAL July 29 1930

20 UNDERTAKER Joseph A Lively — ADDRESS 49 Mount St

sec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 59281

E 59281

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 507 N. Lakewood Av. WARD) 9-10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances Augusta Easterfield

(a) RESIDENCE NO. 507 N. Lakewood Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married.

If married, widowed, or divorced HUSBAND of (or) WIFE of Harry L. Easterfield.

ATE OF BIRTH (month, day, and year) May 5-1877

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	2	21	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

IRTHPLACE (city or town) Hannover
State or country) Germany

0 NAME OF FATHER Robert O. Wentsobel

1 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

2 MAIDEN NAME OF MOTHER unknown

3 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

Informant Harry L. Easterfield
(Address) 507 N Lakewood ave.

[illegible] 1930 [illegible] M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov-17-, 1929, to July 26-, 1930,

that I last saw her alive on July 24-, 1930

and that death occurred, on the date stated above, at 12:10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis & Symptoms

(Signed) Chester Roland, M. D.

7-26, 1930 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL July 29 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

ec.—1-30—M. & T.—250 Bks.

E 59282

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59282

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No.) Caroline & Pine ST. 7-13 (WARD)

REGISTERED NO. 194

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary C. Thiess

(a) RESIDENCE No. 2019 Ashland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced (or) WIFE of Lambert H Thiess

DATE OF BIRTH (month, day, and year) Oct 21 1869

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	9	7 6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Christian Leonhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Rehbein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs Frank Trenner

(Address) 2106 E Madison St.

Filed JUL 29 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28-30

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to July 28, 1930, that I last saw her alive on July 28, 1930 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Myocarditis with Decompensation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Heat Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 7-26-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W W Maudry, M. D.

, 19 (Address) 1 E Fayette Medical

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL July 30 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

...c.—1-12-23—M&T—500 Blks.

E 59283 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

90 E 59283

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 N. Carrollton Ave ST. (WARD) 23

2-FULL NAME Mary Mathews

(a) RESIDENCE No. (Usual place of abode) Asylum ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1866

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

Informant: Lillian B. Robinson

(Address) 822 N. Carrollton Ave

Filed JUL 29 1930 HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1930

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1928, to July 28, 1930, that I last saw h.. alive on July 28, 1930 and that death occurred, on the date stated above, at 4:15 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Wheatley, M. D.

7/28 1930 (Address) 1200 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: July 29, 30

20 UNDERTAKER: John H. Toadvine — ADDRESS 1027 Druid Hill

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59284

CERTIFICATE OF DEATH.

194 E 59284

REGISTERED NO.

1-PLACE OF DEATH
City of BALTIMORE: (a) German Aged Home St. H-27 (Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ed. Julius Horney

(a) RESIDENCE NO. German Aged Home St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 Color or Race: White
5 Single, Married, Widowed, or Divorced: (write the word) Widower

If married, widowed, or divorced
HUSBAND of (or) WIFE of: Wm. Frederick Horney

DATE OF BIRTH (month, day, and year): Nov. 6. 1849

AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	80	8	21	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

BIRTHPLACE (city or town)
(State or country) Germany

10 NAME OF FATHER Edward Horney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna R. Geisler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant German Aged Home
(Address) Balto & Payson Sts.

Filed ..... E. HAMPSON JONES, M. D. ..... Registrar
1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27th 1930

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:
arteriosclerosis
Supervened by
Heart age,
1 (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY
(Secondary)
..... (duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted
If not at place of death!
Did an operation precede death! Date of
Was there an autopsy!
What test confirmed diagnosis?
(Signed) B. D. Cary, M. D.
July 27 1930 (Address) 400 N. Payson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial July 30, 1930

20 UNDERTAKER: Joseph B. Cook ADDRESS 1003 W. Balto St.

c.—1-30—M. & T.—250 Blks

59285

HEALTH DEPARTMENT—CITY OF BALTIMORE

59E 59285

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) Union Memorial Hospital ST. WARD

2-FULL NAME Lillian Johnson (nee Carter) Bay

(a) RESIDENCE NO. Curtis Creek ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

f married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Dec. 15-1912

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	7	11	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Anne Arundel Co
State or country) Md.

0 NAME OF FATHER Addison Johnson

1 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

2 MAIDEN NAME OF MOTHER Agnes Battegate

3 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

Informant Hospital Records.
(Address)

FILED 1930 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26-1930

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1930, to July 26, 1930, that I last saw her alive on July 26, 1930, and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? partial

What test confirmed diagnosis? autopsy

(Signed) Francis W. Gluck, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Marley A. A. Co.	July 29 1930
20 UNDERTAKER Margaret S. Flynn	ADDRESS 14 W Lexington St.

c.—1-30—M. & T.—250 Blks

59286

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 ✓ E 59286

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 3404 Leverton Ave. 26-37 WARD)

2-FULL NAME Edith M. Valentini

(a) RESIDENCE No. 3404 Leverton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 7yr. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	baby

f married, widowed, or divorced HUSBAND of or) WIFE of

ATE OF BIRTH (month, day, and year) Feb. 10, 1930

GE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
		5	18	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) Balto. (State or country) Md.

0 NAME OF FATHER Charles Valentini

1 BIRTHPLACE OF FATHER (city or town) Hagerstown (State or country) Md.

2 MAIDEN NAME OF MOTHER Alberta Nixon

3 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

Informant E. Lady Valentini

(Address) 3404 Leverton Ave

Filed 1930 19 HARRY J. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1930

17

I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to July 28, 1930, that I last saw h[illegible] alive on July 28, 1930, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Allen E. Buckham, M. D.

July 28, 1930 (Address) 3134 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Md. Frankford Cem

DATE OF BURIAL July 31 1930

20 UNDERTAKER Wm. E. Miller & Son

ADDRESS 2334 Eastern Ave.

c.—1-30—M. & T.—250 Blks.

59287

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59287

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 904 E. Lombard ST. 3-5 WARD)

2-FULL NAME Eva Tulkin

(a) RESIDENCE NO. 904 E. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

If married, widowed, or divorced HUSBAND of or) WIFE of Hyman Tulkin

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 637

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Russia

0 NAME OF FATHER Solomon —

1 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

2 MAIDEN NAME OF MOTHER Sarah —

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant (Address) J. Levin 1439 E. Bala St

FILED 7 29 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28-1930

17

I HEREBY CERTIFY, That I attended deceased from about June, 1925, to July 28, 1930,

that I last saw h-r alive on July 28, 1930

and that death occurred, on the date stated above, at 1.20 P. S.T. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 4 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Hampson Jones, M. D.

19 (Address) 1705-7 E. Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holmes Wash Road — DATE OF BURIAL 7-29-1930

20 UNDERTAKER J. Levin, 1439 E Balto. St. — ADDRESS

c.—1-30—M. & T.—250 Bks.

Berich Auerbach

E 59238 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59288

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH Sinai Hospital

TY OF BALTIMORE: (No. Sinai Hospital ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Berich Auerbach

(a) RESIDENCE NO. 1535 E Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6½ yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) — 1860

GE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
70 years	70	—	—	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book-keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Baltimore City Russia

0 NAME OF FATHER Solomon Auerbach

1 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

2 MAIDEN NAME OF MOTHER Bessa Kopher

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Daughter in Law

(Address) 1535 E Pratt

9 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 - 1930

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to July 28, 1930

that I last saw him alive on July 28, 1930,

and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Hypertensive C. V. R. disease

Uremia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary), Arthemia, Emphysema

(duration) 25 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Renal function

(Signed) Meyer M. Boyles, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 7-29-1930

20 UNDERTAKER Jacs Levin, 1439 E Baltimore St — ADDRESS

c.—1-30—M. & T.—250 Blks.

E 59289

E 59289 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 2720 Hugo Ave (St.) 9-46 (WARD)

2-FULL NAME Laura J. Larmore

(a) RESIDENCE NO. 2720 Hugo Ave (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of John S. Larmore

ATE OF BIRTH (month, day, and year) Dec 27-1853

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	7	1	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Bristol Md

0 NAME OF FATHER Wm Dunn

1 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

2 MAIDEN NAME OF MOTHER Percila Dunn

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Alice Larmore

(Address) 2720 Hugo Ave

Filed 9-1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28/30

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to July 28, 1930,

that I last saw her alive on July 28, 1930,

and that death occurred, on the date stated above, at 11. O. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M.D.

7/31/30 (Address) 2367 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Md — DATE OF BURIAL July 30, 1930

20 UNDERTAKER Geo M. Enell & Son — ADDRESS 811 N Howard

c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59290

CERTIFICATE OF DEATH

25-001

E 59290

REGISTERED NO.

1—PLACE OF DEATH Home for Incurables — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 700 W. 40th St. ST. 13-57 WARD)

2—FULL NAME Emma J. Hartman

(a) RESIDENCE NO. Home for Incurables ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widowed.

married, widowed, or divorced
HUSBAND of (or) WIFE of A. Stewart Hartman

TE OF BIRTH (month, day, and year) Mar. 27, 1851

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	4	1	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work None.

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) Emmittsburg - (State or country) Maryland

NAME OF FATHER George W. Rowe

BIRTHPLACE OF FATHER (city or town) ? (State or country)

MAIDEN NAME OF MOTHER Ellie Keehan

BIRTHPLACE OF MOTHER (city or town) Emmittsburg Md. (State or country)

Informant Hospital Records.

(Address)

Filed 7-19-30 JOHNSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 - 1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930 to July 28, 1930

that I last saw her alive on July 28, 1930

and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Left side hemiplegia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho - pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Case

(Signed) W. W. B. Mayo M. D.

7/28 1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmitsburg Md

DATE OF BURIAL July 30 1930

20 UNDERTAKER M. F. Shuff

ADDRESS Emmitsburg Md

Spec—12-23-21—E.B.R.S.—400 Blks.

E 59291 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59291

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH — Registered No. .....

City of BALTIMORE: (No. 3123 Leed St. 20-70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Staples

(a) Residence No. 3123 Leed St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): married

6-If married, widowed, or divorced HUSBAND of (or) WIFE of: Jane Staples

7-DATE OF BIRTH (month, day and year): Feb 15/1865

8-AGE: 65 yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

9-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Catering.
(c) Name of employer: Mr Gaston Baltimore Co

10-BIRTHPLACE (city or town) (State or Country): Virginia

10-NAME OF FATHER: Mark Staples

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Nat Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

(Informant) Jane Staples
(Address) 3123 Leeds St.

Filed ..... G. HAMPSON JONES, M. D.

1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 26/1930

17- I HEREBY CERTIFY, That I attended deceased from November 15 1929 to July 26th 1930 that I last saw h[illegible] alive on July 20th 1930, and that death occurred, on the date stated above, at 7-45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) One yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of .....

Was there an autopsy? No ..... only

What test confirmed diagnosis? Clinical findings

(Signed) Bonnell Largo M. D.

, 19 (Address) 2937 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western Star Cemetery — DATE OF BURIAL, July 29, 1930

20-UNDERTAKER: Dr. Katie R. Williams — ADDRESS 3224 Schroeder St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Merville Bailey

E 59292

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59292

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 536 W Conaway St. 22-30 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Merville Bailey

(a) RESIDENCE. No. 536 W. Conaway ST., ..WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of — Widow

DATE OF BIRTH (month, day, and year) March 25 1873

AGE	Years	Months	Days	If LESS than 1 day, .. hrs. or .. min.
	57	4	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) — Home work

(c) Name of employer — Home

BIRTHPLACE (city or town) (State or country) — Baltimore

10 NAME OF FATHER — John Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country) — Md.

12 MAIDEN NAME OF MOTHER — Sarah Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — Md

Informant (Address) — Maud Elliott 916 Bernard Place

Filed 29 1930 . 19 — C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1930

17

I HEREBY CERTIFY, That I attended deceased from July 1 . 1930 . to July 26 . 1930

that I last saw h alive on July 25 . 1930

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic symptoms

(Signed) C. W. Howe . M. D.

July 28 1930 (Address) 712 S. Wolfe Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Mt. Auburn Cemetery

20 UNDERTAKER — D. Mrs Katie R. Williams

DATE OF BURIAL — July 30 1930

ADDRESS 3220 Schroeder St

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59293 ✓ 194 E 59293

E 59293

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No 128 N Calhoun St 19-27 WARD)

2-FULL NAME Lydia Ann Tucker

(a) RESIDENCE NO. 128 W Calhoun St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Lemuel J Tucker

ATE OF BIRTH (month, day, and year) Oct 12 1842

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	9	15	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

IRTHPLACE (city or town) New York
(State or country) New

0 NAME OF FATHER Samuel Barber

1 BIRTHPLACE OF FATHER (city or town) N J.
(State or country)

2 MAIDEN NAME OF MOTHER Mary Dewell

3 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

Informant Mrs. Thomas Saunders
(Address) 128 W Calhoun

Filed 7-29 1930 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27-1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to July 27, 1930, that I last saw h[illegible] alive on July 27, 1930, and that death occurred, on the date stated above, at 5-20 P. m. D.S.T.

The CAUSE OF DEATH* was as follows:

Heat prostration + Senility
(duration) ....yrs. ....mos 17 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema
(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Baumgardner M. D.

7/28 1930 (Address) 2216 Garrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul M. E. Ch. South Cem. Catonsville Md

DATE OF BURIAL July 30 1930

20 UNDERTAKER Wm J Tickner Sons

ADDRESS N W Pa

c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 59294

CERTIFICATE OF DEATH

E 59294

REGISTERED NO. 13457

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.) Home for Incurables ST. 40th WARD)

2—FULL NAME Mrs. Anna Benedict Dewilbiss

(a) RESIDENCE NO. Home for Incurables ST., 40th WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Widowed

married, widowed, or divorced HUSBAND of (or) WIFE of John S. Dewilbiss

ATE OF BIRTH (month, day, and year) Sept. 18-1840

E	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
89	90	10	9	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

RTHPLACE (city or town) Uniontown
State or country) Carroll Co. Md.

0 NAME OF FATHER Nathaniel Bendith

1 BIRTHPLACE OF FATHER (city or town)
(State or country) Uniontown, Carroll Co. Md.

2 MAIDEN NAME OF MOTHER Elizabeth Bolles

3 BIRTHPLACE OF MOTHER (city or town)
(State or country) Uniontown, Carroll Co. Md

Informant Home for Incurables Records
(Address) 40th & Pennsylvania Ave. Balto. Md.

Filed 7-29 1930 HAMPSON JONES M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27-1930

17 I HEREBY CERTIFY, That I attended deceased from July 24 19 21 to July 27 1930

that I last saw her alive on July 27, 1930

and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis -
Chronic Myocarditis -

(duration) 8 yrs. mos. ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) W. B. Thays M. D.

7/27 1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Co Md Uniontown M. E. Cem

DATE OF BURIAL July 30 1930

20 UNDERTAKER Wm J Gickner & Sons

ADDRESS N. Y. Pa

...c.—1-30—M. & T.—250 Bks.

E 59295

E 59295 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General St. [illegible] (WARD)

2-FULL NAME Charles Griffith, Jr.

(a) RESIDENCE NO. Severn, Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Jan 2 1929

AGE: Years 1 | Months 6 | Days 26 | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) A. A. Co. (State or country) Md.

10 NAME OF FATHER Charles Griffith, Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co. Md.

12 MAIDEN NAME OF MOTHER Lillian Marie Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md.

Informant Charles Griffith Sr.

(Address) A. A. Co. Md.

C. HAMPSON JONES, M. D., Registrar

Filed [illegible] 19 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29-30

17 I HEREBY CERTIFY, That I attended deceased from 7-13, 1930, to 7-29, 1930, that I last saw h[illegible] alive on 7-29, 1930, and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Toxaemia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Encephalitis (Infection)

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical Signs

(Signed) Joseph Laukaitis, M. D.

19 (Address) South Baltimore Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friendship Cem A. A. Co. Md.

DATE OF BURIAL July 31, 30

20 UNDERTAKER Wm. J. Tickner & Sons

ADDRESS N. Paca

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59296

CERTIFICATE OF DEATH

194 E 59296

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1225 Eager St. 10-14 Ward)

2-FULL NAME Rev. Christian Olert. Olert C. SSR.

(a) RESIDENCE NO. 1225 Eager St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16 1870

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
60	—	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Priest
(b) General nature of industry, business, or establishment in which employed (or employer) 618
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Christian Olert

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER C Hagen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant St. James Church
(Address) 1225 Eager

15 Filed ... 19... HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28. 30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Senility

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. T. Riley, M. D.

July 28, 1930 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 30 1930
20 UNDERTAKER	ADDRESS
Feney Hoech & Sons, Inc.	1301 E Eager St

C.—1-30—M. & T.—250 Bks.

9297 E 59297

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

TY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Neal

(a) RESIDENCE NO. Preston & Valley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? 76 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) May 29th 1846

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84	1	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER William Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Anna Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant Little Sisters of the Poor

(Address) Preston & Valley

Filed JUL 30 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 28, 1930, that I last saw h... alive on July 28, 1930, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

1. Arteriosclerosis
2. Senility

Contributory (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) D. Richmond Ross, M. D.

July 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County

DATE OF BURIAL July 31, 1930

UNDERTAKER Henry Koch Sons

ADDRESS 1301 E Eager St

rc.—1-30—M. & T.—250 Bks.

59298

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 59298

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore, Md.

TY OF BALTIMORE: (No. 1807 Eutaw Place ST. 14-20 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenie Lobe Eiseman

(a) RESIDENCE NO. 1807 Eutaw Place WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
nale	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of M. B. Eiseman

ATE OF BIRTH (month, day, and year) Nov. 13 1860

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	3	14	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) Balto. (State or country) Md.

0 NAME OF FATHER Isaac Lobe

1 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

2 MAIDEN NAME OF MOTHER Esther Eytinge

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

Informant Mr. M. B. Eiseman

(Address) 1807 Eutaw Place

Filed ...1930... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 30.

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1920, to July 27, 1930, that I last saw h.m alive on July 27, 1930, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

about

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Proctoscopic Exam

(Signed) Theodore H. Morrison M. D.

, 19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 7/30/1930

20 UNDERTAKER Harid Sondheim & Son

ADDRESS 1902 Eutaw Place

THAMPSON JONES, M. D.

.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59299

CERTIFICATE OF DEATH

44 E 59299

REGISTERED NO.

—PLACE OF DEATH

TY OF BALTIMORE: (No. 900 Park Avenue ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Robert Madden

(a) RESIDENCE NO. 900 Park Avenue ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

rth of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	W.	Married

married, widowed, or divorced HUSBAND of (or) WIFE of Anna R. Madden

TE OF BIRTH (month, day, and year) 1885

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

CUPATION OF DECEASED

) Trade, profession or rticular kind of work Waiter 90

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) Maryland
tate or country)

NAME OF FATHER Nicholas Madden

BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

MAIDEN NAME OF MOTHER Eliza Walker

BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

Informant Anna R. Madden
(Address) 900 Park Ave.

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 25, 1930, that I last saw him alive on July 25, 1930 and that death occurred, on the date stated above, at 11:50 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Esophagus

Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Watts, M. D.

, 19 (Address) 1021 Madison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Luke Cemetery	July 29, 1930
20 UNDERTAKER Mrs R. G. Elliott	ADDRESS 1775 Ashland Ave

e.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59300

CERTIFICATE OF DEATH

74-001

E 59300

REGISTERED NO.

1—PLACE OF DEATH

TY OF BALTIMORE: (No. 172 E Lafayette Ave ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilhelmina Cole.

(a) RESIDENCE NO. 172 E Lafayette Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 8 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widowed.

married, widowed, or divorced
HUSBAND of
(or) WIFE of William G. Cole.

TE OF BIRTH (month, day, and year) Jan-4-1848

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	6	22	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work At home

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

THPLACE (city or town) Baltimore
tate or country) Maryland.

NAME OF FATHER Wm Bramble

BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

MAIDEN NAME OF MOTHER Sarah Hicks

BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

Informant Charles Cole
(Address) 172 E. Lafayette Ave.

9 1930 HAMILTON JONES, M. D.
19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26/1930

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1929, to July 26, 1930, that I last saw h alive on July 26, 1930 and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

(Cerebral Hemorrhage)
Paralysis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Alf L Gagl, M. D.

7/28. 1930 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Baltimore Cemetery

DATE OF BURIAL
July 29 1930

20 UNDERTAKER
Walter Goodwin

ADDRESS
412 N Broadway

Cor.—10-10-29—A Co.—100 Blks.

E 59301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74 09

E 59301

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 518 Overdale Rd., St., Ten Hills 28-71 Ward)

2-FULL NAME Mary R. Miller

(a) RESIDENCE NO. 518 Overdale Rd. St., Ten Hills Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Edward H. Miller

6 DATE OF BIRTH (month, day, and year) Sept. 17, 1852

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	77	10	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Pa.

10 NAME OF FATHER Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Paul W. S. Miller
(Address) 518 Overdale Rd.

15 7/29/1930 C. HAMPSON JONES, M.D. Registrar
By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O'Donnell M. D.

July 29 1930 (Address) Brooklyn Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 7/30/30

20 UNDERTAKER Harry H. Mitzke 4101 Edmondson Ave

ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

59302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-001 E 59302

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No.) Fayette & Calhoun ST., 21-48 WARD 8

2-FULL NAME Baby Edward Joseph Flaherty

(a) RESIDENCE NO. 4662 Kernwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) July 27th. 1930

AGE	Years	Months	Days	If LESS than 1 day hrs. or 56 min.
				14

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Edward Hall Flaherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Edna F. Callahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

Informant Edward H. Flaherty

(Address) 4662 Kernwood Ave.

Filed 9 1930 C. H. Morton Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-28 . 1930

17

I HEREBY CERTIFY, That I attended deceased from 7-27 . 1930 . to 7-28 . 1930 .

that I last saw him alive on 7-28 . 1930 .

and that death occurred, on the date stated above, at 2:20 P m.

The CAUSE OF DEATH* was as follows:

Respiratory failure

Prematurity 34 weeks

development

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Premature position

Brain Extraction (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No -

What test confirmed diagnosis? Examination

(Signed) M. B. Schreiber. M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 7/29/30

20 UNDERTAKER Harry A. Nitzke. 410 — ADDRESS Edmondson Ave.

...—2-29-28—L. F. S.—500 Bks.

59303

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117

E 59303

REGISTERED NO.

1—PLACE OF DEATH

TY OF BALTIMORE: (N) Bon Secours Hospital ST., (WARD) 19-28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Maguire

(a) RESIDENCE NO. 1512 Mt Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 31 yrs. 1 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	white	single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) July 14th 1899.

E Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
31	—	15.	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work Clerk.

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer B & O R.R.

RTHPLACE (city or town) (State or country) Baltimd.

NAME OF FATHER Andrew Maguire

BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

MAIDEN NAME OF MOTHER Margaret Mee

BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mr Andrew Maguire

(Address) 1259 Westend Ave

1930 HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29. 1930

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to July 29, 1930, that I last saw h. alive on July 29, 1930 and that death occurred, on the date stated above, at 10 15 9 m.

The CAUSE OF DEATH* was as follows:

Appendicitis, Acute

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of July 25 1930

Was there an autopsy?

What test confirmed diagnosis? Clinical + operative

(Signed) Chas D Stolesteh, M. D.

19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Aug 1st 1930
20 UNDERTAKER John J Cowan & Son.	ADDRESS 901 Holliday St

cc.—1-12-23—M&T—500 Blks.

59304

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59304

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 376 Mt. Olivet Ave. (St.)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis D. Silver

(a) RESIDENCE NO. 376 Mt. Olivet Ave. ST.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Silver

DATE OF BIRTH (month, day, and year): Sept. 17, 1883

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	46	10	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Roofer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Italy

10 NAME OF FATHER: Raphael Silver

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Philamena Grabastino

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

Informant: Mrs. Annie Silver

(Address) 376 Mt. Olivet Ave.

29 1930 JAMESON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27, '30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1929, to July 27, 1930, that I last saw h/m alive on July 27, 1930, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Indefinite

CONTRIBUTORY (Secondary) Acute dilatation of heart

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. H. Campbell, M. D.

7/28, 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 1/31 1930

20 UNDERTAKER: Edward Foulk

ADDRESS: 2358 Woodbourne Ave.

M. & T.—100 B—50L

59305

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002

E 59305

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen Hosp 15-21 WARD)

2-FULL NAME Katherine K. Klein

(a) RESIDENCE NO 1903 N. Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

married, widowed, or divorced HUSBAND of (or) WIFE of Robt Klein.

6 DATE OF BIRTH (month, day and year): Jan 24 1854

AGE: Years 75 | Months 6 | Days 5 | If LESS than 1 day, hrs. or min.

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

8 BIRTHPLACE (city or town) (State or country): Maryland

9 NAME OF FATHER

BIRTHPLACE OF FATHER (city or town) (State or country)

10 MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (city or town) (State or country)

11 Informant: John J. Klein

12 (Address) 1903 N. Payson

13 Filed 9 1930 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): July 27th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? N Date of

Was there an autopsy? N

What test confirmed diagnosis? Clinical

(Signed) July 27th 1930 H. Schmick, M. D. Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: July 30 1930

UNDERTAKER: Martin Fakey & Sons

ADDRESS: 1821 N. North Ave

C.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59306

CERTIFICATE OF DEATH.

129 E 59306

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 S. Bethel ST., 3-4 WARD)

2-FULL NAME Martha L. Carr

(a) RESIDENCE NO. 307 S. Bethel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow

If married, widowed, or divorced HUSBAND of or) WIFE of Wm. A. Carr

DATE OF BIRTH (month, day, and year) [illegible] 1862

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

BIRTHPLACE (city or town) Balto. (State or country) Md.

10 NAME OF FATHER James Burns

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Martha Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

Informant Wm Carr (Address) 307 S. Bethel st.

C. HAMPSON JONES, M. D. Registrar

Filed JUL 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 - 1930

17 I HEREBY CERTIFY, That I attended deceased from February 8, 1930, to July 25, 1930, that I last saw her alive on July 25, 1930, and that death occurred, on the date stated above, at 9 [illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 5 mos 17 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests and autopsy

(Signed) Samuel Silverstein M. D.

, 19 (Address) 727 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lemmel Cemetery

DATE OF BURIAL July 29, 1930

UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1726 [illegible]

Spec.—1-10-21—M&T—1500 Bks.

E 59307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 E 59307

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 343 Preston ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie White

(a) RESIDENCE NO. 343 Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: James White

DATE OF BIRTH (month, day, and year): 1858

AGE: Years 72 Months Days

If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

Informant: Edward L. Fink

(Address): 343 Preston St.

Filed JUL 29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 24th, 1930 to July 29, 1930.

that I last saw h[illegible] alive on July 24th, 1930,

and that death occurred, on the date stated above at 4 A.M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Heart Prostate

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis? Physical

Signed: H. Lee Ott, M. D.

(Address) 524 Mad- ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: July 30 1930

UNDERTAKER: Bernard A. Fink

ADDRESS: 756 Washington Blvd.

c.—1-30—M. & T.—250 Blks.

59308

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 E 59308

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. Mt Hope Retreat ST. 19-27 WARD)

2-FULL NAME Lawrence Lowe camp!

(a) RESIDENCE NO. 1850 W. Mulberry ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

ngth of residence in city or town where death occurred 60 yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Single

married, widowed, or divorced HUSBAND of (or) WIFE of none

ATE OF BIRTH (month, day, and year) Oct 29. 1869

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	9	2	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

RTHPLACE (city or town) Baltimore

(State or country) Md

0 NAME OF FATHER Charles B Lowecamp

1 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country) Germany

2 MAIDEN NAME OF MOTHER Gertrude Bailey

3 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

Informant Mt Hope Retreat

(Address) Mt Hope Retreat

[redacted] M.D.

[redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27. 1930

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1930, to July 27, 1930, that I last saw h[illegible] alive on July 26, 1930, and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Epilepsy

Unknown (duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Idiot

(duration) 60 yrs. 9 mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hall M. D.

19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	July 30 1930
20 UNDERTAKER	ADDRESS
Lilly & Zeiler Inc.	4035 W. Wolfe

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59309

CERTIFICATE OF DEATH

1934 E 59309

1-PLACE OF DEATH

City of Baltimore: (No. 227 S. Collington Ave. Ward) 13

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Bluem

(a) RESIDENCE NO. 227 S. Collington Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Bluem

6 DATE OF BIRTH (month, day, and year): Feb. 2, 1857

7 AGE: Years 73 ~~77~~ | Months 5 | Days 26 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Long Shoreman
(c) Name of employer

9 BIRTHPLACE (city or town) ~~Germany~~
(State or country) Germany

10 NAME OF FATHER Jacob Bluem

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant George J. Bluem
(Address) 2270 Collington

15 Filed ... 1930 ... 19 ... HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Exhaustion

(duration) ... yrs. ... mos. 1½ ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton M. D.

1930 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	July 30 1930
20 UNDERTAKER: Lilly & Zeiler Inc.	ADDRESS: 4032 E. Monument St

Cor.—10-10-29—A Co.—100 Bks.

E 59310

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59310

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Procter Hosp. Ward) 7-11-24

2-FULL NAME Ernest Selden

(a) RESIDENCE NO. 342 Dolphin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE: Years 43 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Mpt Md
(State or country) Md

10 NAME OF FATHER Frank Selden

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Cornelia Wilson

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mary Booker
(Address) 342 Dolphin St.

Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Aortic Insufficency

3 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 342 Dolphin

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. B. Buck M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Va

DATE OF BURIAL: 7/29 1930

20 UNDERTAKER: Samuel Kennedy

ADDRESS 378 Belle

1930

AMOS JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

E 59311 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59311

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital W. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME H. Winter Davis Cross.

(a) RESIDENCE NO. 154 N. Gay St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

DATE OF BIRTH (month, day, and year) ----------

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Thomas A. Cross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Arrabella Duvall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant J. H. A. Rogan

(Address) 704 Court Square Bldg

1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1930, to July 28, 1930, that I last saw him alive on July 28, 1930, and that death occurred, on the date stated above, at 9:10 p.m.

The CAUSE OF DEATH* was as follows:

Uremia (?)

(?) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Hugh Trimble, M. D.

, 19 (Address) St Agnes Hospital city.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 7/30/1930

20 UNDERTAKER Henry H. Mears & Son

ADDRESS 805 N. Calvert

c.—1-30—M. & T.—250 Blks.

Dr Costello 335 E. 31st St

E 59312 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59312

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 346 E 27th St ~~St~~ 12-50 (WARD)

2-FULL NAME Anna Elizabeth Ziegler

(a) RESIDENCE NO. 346 E. 27th St. WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Married

f married, ~~widowed, or divorced~~ ~~HUSBAND of~~ or) WIFE of Charles

ATE OF BIRTH (month, day, and year) 9/7/1869

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	10	22	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

IRTHPLACE (city or town) York Pa
(State or country)

0 NAME OF FATHER Michael Morningstar

1 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

2 MAIDEN NAME OF MOTHER Mary A Hess

3 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

Informant Charles Ziegler

(Address) 346 E. 27th St

9-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to July 29, 1930,

that I last saw h[illegible] alive on July 28, 1930,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Fatty Heart

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. Costello M. D.

, 19 (Address) 335 E 31st St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	7/31/30
20 UNDERTAKER W. M. Cook 1217	ADDRESS St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59313

CERTIFICATE OF DEATH

194 E 59313

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 920 Hanover St. St. 23-31 Ward)

2-FULL NAME Eliyn Pavlikovich.

(a) RESIDENCE NO. 920 Hanover St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	56	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer,
(b) General nature of industry, business, or establishment in which employed (or employer): B.& O.R.R.Co.
(c) Name of employer

9 BIRTHPLACE (city or town): Russia.
(State or country)

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Do not know.

14 Informant: Max Sharr.
(Address) 920 Hanover St.

19 [illegible] 1930 L. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Prostration.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, M. D.

7/29, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Russian Cemetery Camp Meade Rd

DATE OF BURIAL: 7/30/1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul St

c.—1-30—M. & T.—250 Blks.

St Ottawa 2708 Hudson Ferry Rd Lakeland ✓

59314

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 59314

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 2605 Oswego Ave St.) (Apt. No.) 5-58

2-FULL NAME Jacob Smith

(a) RESIDENCE NO. 2605 Oswego Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, ~~widowed, or divorced~~ HUSBAND of ~~or) WIFE of~~ Rebecca Elizabeth

ATE OF BIRTH (month, day, and year) Oct 3 1856

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	~~73~~ 68	9	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

IRTHPLACE (city or town) (State or country) Germany

0 NAME OF FATHER Unknown

1 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

2 MAIDEN NAME OF MOTHER Unknown

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant John H. Wiedemann

(Address) 2605 Oswego Ave

Filed ...1930... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28/30

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1930, to July 28, 1930, that I last saw him alive on July 25, 1930, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) no yrs. no mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Nurse

(Signed) Raymond J Glenn, M. D.

7/28 1930 (Address) 2704 Hudson Ferry Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 7/30/1930

UNDERTAKER P. Wm Cook

ADDRESS 1217 St Paul St

...—1-32-23—M&T—500 Blks.

E 59315

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 E 59315

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.) 3202 Vera ST. 25-11 (WARD)

2-FULL NAME William C. Goodrick

(a) RESIDENCE NO. 3202 Vera ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX: M | 4 COLOR OR RACE: W | 5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed or divorced HUSBAND of (or) WIFE of: Elizabeth Goodrick

DATE OF BIRTH (month, day, and year): 1858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Washington D.C.

10 NAME OF FATHER: Hugh Goodrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Marie Medders

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

Informant: Elizabeth Goodrick

(Address): 3202 Vera St

C. HAMPSON JONES, M. D.

Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1930

17

I HEREBY CERTIFY, That I attended deceased from Mar. 17, 1930, to July 28, 1930,

that I last saw him alive on July 28, 1930,

and that death occurred, on the date stated above, at 9:20 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Indefinite ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. E. Campbell M. D.

7/28 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: 7/31/1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul St

pec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59316

CERTIFICATE OF DEATH.

001 ✓ E 59316

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No.) 1008 N. Fulton Ave. (St.) H-22 (Ward)

2-FULL NAME Robert Pritchard Brooks.

(a) RESIDENCE. (No.) 1008 N. Fulton Ave (St.) (Ward.)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Brooks.

DATE OF BIRTH (month, day, and year) Feb 16. 1848

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	5	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Norfolk. Va.

10 NAME OF FATHER James Madison Brooks.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk. Va.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

Informant R. J. Gilbert

(Address) 1008 N. Fulton Ave.

Filed . 19 Registrar

C. HAMPSON JONES, M. D.

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1930, to July 29, 1930, that I last saw him alive on July 28, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Arteriosclerosis -
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophic cirrhosis of Liver.
(duration) ? yrs. mos.

18 Where was disease contracted If not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exams.

(Signed) Charles L. Warner, M. D.

, 19 (Address) 3312 Egerton Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetary

DATE OF BURIAL 7/31/30

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

c.—1-30—M. & T.—250 Blks

E 59317 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59317

43

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 3101 Clearview ave ST. 27-43 WARD

2-FULL NAME John Bisco Sanner

(a) RESIDENCE NO. 3101 Clear View ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	white	married

f married, widowed, or divorced HUSBAND of (or) WIFE of Katherine

ATE OF BIRTH (month, day, and year) DEC 27 1848

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	7	1	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist o/b

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer —

IRTHPLACE (city or town) (State or country) Balto md

0 NAME OF FATHER Joseph Sanner

1 BIRTHPLACE OF FATHER (city or town) (State or country) md

2 MAIDEN NAME OF MOTHER Martha Sutton

3 BIRTHPLACE OF MOTHER (city or town) (State or country) md

Informant Mrs. Katherine Sanner

(Address) 3101 Clear View ave

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28/30

17 I HEREBY CERTIFY, That I attended deceased from May 19 30, to 7/28 19 30,

that I last saw him alive on 7/28 19 30,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? an Physical.

What test confirmed diagnosis?

(Signed) Lyle W. Kelly, M. D.

19 (Address) 5710 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Ridge Cem.

DATE OF BURIAL 7/30/30

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

c.—1-30—M. & T.—250 Bks.

59318 HEALTH DEPARTMENT—CITY OF BALTIMORE 59318

CERTIFICATE OF DEATH. 100-09

1-PLACE OF DEATH Baltimore City Hospital ST. 6-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.

2-FULL NAME Mary A. Burns

(a) RESIDENCE NO. 148 N Stiles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	unknown

married, widowed, or divorced HUSBAND of (or) WIFE of —

ATE OF BIRTH (month, day, and year) March 30, 1848

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
82		3	27	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

IRTHPLACE (city or town) Baltimore

State or country) Md.

0 NAME OF FATHER Thomas A Murray

1 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

2 MAIDEN NAME OF MOTHER Mary A. ?

3 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country) Ireland

Informant Family

(Address) Baltimore City Hosp.

HAMPSON JONES, M. D. Registrar

1930, 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27-30

17 I HEREBY CERTIFY, That I attended deceased from 1-17, 1929, to 7-27, 1930, that I last saw h alive on 7-27, 1930, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis

(duration) Indefinite

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Fred M. Duckworth, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Patrick

DATE OF BURIAL July 30, 1930

20 UNDERTAKER John A. Moran

ADDRESS 000 E. Balto

c.—1-30—M. & T.—250 Blks

E 59319

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59319

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1910 E. 30th St. 9-46 ST., WARD)

TY OF BALTIMORE: (No.

2-FULL NAME Ella M. Crail (Mrs)

(a) RESIDENCE NO. 1910 E. 30th St. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

ngth of residence in city or town where death occurred 9 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

If married, widowed, or divorced HUSBAND of or) WIFE of: Divorced

ATE OF BIRTH (month, day, and year) Dec. 31st 186

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	6	28	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

IRTHPLACE (city or town) (State or country): Indiana

0 NAME OF FATHER: J. D. James

1 BIRTHPLACE OF FATHER (city or town) (State or country): Kentucky

2 MAIDEN NAME OF MOTHER: Hannah James

3 BIRTHPLACE OF MOTHER (city or town) (State or country): Indiana

Informant (Address): John F. Arneal, 1910 E. 30th Street

19 30 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JULY 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1930, to July 28, 1930, that I last saw h alive on July 28, 1930, and that death occurred, on the date stated above, at 3 PM EST

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

I (Signed) F. H. Kilzer, M. D.

July 29, 1930 (Address) 2900 Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood cemetery

DATE OF BURIAL: July 30 1930

20 UNDERTAKER: Chas. G. Black

ADDRESS: 742 W. North ave

c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59320

CERTIFICATE OF DEATH

129 E 59320

REGISTERED NO.

1—PLACE OF DEATH

TY OF BALTIMORE: (No.) 2814 N. Calvert ST., 17-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susan Carrie Turner

(a) RESIDENCE NO. 2814 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widow

married, widowed, or divorced HUSBAND of (or) WIFE of Howe E. Turner.

TE OF BIRTH (month, day, and year) Sept 13/1856

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	15	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work At home

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

THPLACE (city or town) Frederick Co. (State or country) Md

NAME OF FATHER Nicholas E. Norris

BIRTHPLACE OF FATHER (city or town) Frederick Co (State or country) Md.

MAIDEN NAME OF MOTHER Mary A. McKinstry

BIRTHPLACE OF MOTHER (city or town) Frederick Co (State or country) Md.

Informant Paul A. Harris

(Address) 2814 N. Calvert St.

F[illegible], 19[illegible] THOMPSON JONES, M. D. Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28/30.

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1930, to July 28, 1930, that I last saw h[illegible] alive on July 27, 1930 and that death occurred, on the date stated above, at 155 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
x Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Thomas Jones, M. D.

7/29, 1930 (Address) 846 W 36 St. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lemonville Md Linganore Cemetery

DATE OF BURIAL July 31/1930

ADDRESS

20 UNDERTAKER Horace F. Burger 3131 Falls Rd

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59321

CERTIFICATE OF DEATH. X - 44

E 59321

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. University Hospital ST. 1-30 WARD)

2-FULL NAME George Gehr

(a) RESIDENCE NO. Westminster Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
ale	White	married

If married, widowed, or divorced HUSBAND of or) WIFE of

ATE OF BIRTH (month, day, and year) July 23 - 1851

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	—	4 7	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) maryland

0 NAME OF FATHER Denton Gehr

1 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

2 MAIDEN NAME OF MOTHER Sarah Noel

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

Informant Denton Gehr

(Address) Westminster md

Filed 19 C. HARRISON JONES, M. D. Registrar

0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-30-30

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to July 30, 1930, that I last saw him alive on July 30, 1930, and that death occurred, on the date stated above, at 4:40 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) anginal myocardial insufficiency (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George H. Yeager, M. D.

7/30, 1930 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster md

DATE OF BURIAL Aug 2 1930

20 UNDERTAKER H H Bankard & Son

ADDRESS Westminster Md

c.—1-30—M. & T.—250 Blks

E 59322 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

194 E 59322

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE (No. 3417 Park Heights ave ST., 45-58 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Schwartzberg

(a) RESIDENCE NO. 3417 Park Heights ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Widow

f married, widowed, or divorced HUSBAND of or) WIFE of Late Jacob

ATE OF BIRTH (month, day, and year) 1857

GE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	73	—	—	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Russia

0 NAME OF FATHER Louis Romm

1 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

2 MAIDEN NAME OF MOTHER Rella

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant A. Schwartzberg

(Address) 1510 Eight st

Filed 1930 19 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29/30

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to July 29, 1930.

that I last saw h[illegible] alive on July 29, 1930, and that death occurred, on the date stated above, at 9045 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Glas weather

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

7/29/30 (Address) 1515 Rutland ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rutno Rosedale

DATE OF BURIAL July 30, 1930

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto st

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59323

CERTIFICATE OF DEATH

X 18 SE 59323

REGISTERED NO. 24-33

1-PLACE OF DEATH South Baltimore General Hospital
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. North 6th St. Glen Burnie A.A. Co. Md. Ward)

2-FULL NAME Charles Sadlowski.

(a) RESIDENCE NO. North 6th St. Glen Burnie, A.A. Co. Md. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ---- How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) September 22, 1909

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	20	10	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia.
(State or country)

10 NAME OF FATHER John Sadlowski.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia.

12 MAIDEN NAME OF MOTHER Emily Soczyuski.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia.

14 Informant Joseph Bucheck.
(Address) North 6th St. Glen Burnie.

15 Filed 7 30 1930 19 [illegible] JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of Cervical Vertebrae.
Dove into shallow water.
Occidental Death.
(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? St. Ormstead. July 27, 1930
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry
(Signed) Otto U. Eisenhardt, M. D.
7/29. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. DATE OF BURIAL 7-30, 1930

20 UNDERTAKER Bernard C. Harlr. ADDRESS 1004 E Baltimore St

c. —2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59324 | 129 | E 59324

REGISTERED NO.

1—PLACE OF DEATH

TY OF BALTIMORE: (No. 523 N Mount ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Perkins

(a) RESIDENCE NO. 523 N Mount ST., WARD
(Usual place of abode)

(If non-resident give city or town and State)

rth of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

married, widowed, or divorced
(or) WIFE of Frederick Perkins

TE OF BIRTH (month, day, and year) unknown

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
pprox	59			

CUPATION OF DECEASED

) Trade, profession or rticular kind of work at home

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

THPLACE (city or town) Richmond Va
tate or country)

NAME OF FATHER Wm. Cosby Va

BIRTHPLACE OF FATHER (city or town)
(State or country)

MAIDEN NAME OF MOTHER Mary Jones Va.

BIRTHPLACE OF MOTHER (city or town)
(State or country)

Informant Fredrick Perkins
(Address) 523 N. Mount

Filed ..., 19... C. H. JONES, M. D. Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1930

17 I HEREBY CERTIFY, That I attended deceased from May, 1930, to July 27, 1930, that I last saw her alive on July 26, 1930 and that death occurred, on the date stated above at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchopneumonia Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis and Pleurisy

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. H. Young, M. D.

7/28, 1930 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL July 30 1930

20 UNDERTAKER Virginia A. Brooks

ADDRESS 1463 N Carey

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59325

CERTIFICATE OF DEATH.

31 E 59325

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 621 N. Bond St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Forest

(a) RESIDENCE NO. 621 N. Bond St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Forest, nee Jones

6 DATE OF BIRTH (month, day, and year) Feb. 20-1885

7 AGE: Years 45 Months 6 Days 8 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer St. Marys Co. Md

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER Adam Forest

11 BIRTHPLACE OF FATHER (city or town) St. Marys Co. Md

(State or country)

12 MAIDEN NAME OF MOTHER Maria Henson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Richmond Va.

14 Informant Maggie Summers

(Address) 1431 E. Monument St.

15 Filed ..... 19 ..... Registrar.

0 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1930

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

28 (signed) G. O. Radcliffe M. D.

(Coroner)

, 19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

In place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashley Mem. Date of Burial July 31 1930

20 UNDERTAKER Chas. H. Johnson ADDRESS 1411 N. Caroline St.

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 59326

E 59326

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS ST. 5-X WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO.

2-FULL NAME Joseph Smith

(a) RESIDENCE NO. 123 N. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single.

f married, widowed, or divorced HUSBAND of (or) WIFE of

ATE OF BIRTH (month, day, and year) June 17, 1898.

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
32	1	9	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bus Boy 07

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer unknown.

RTHPLACE (city or town) (State or country) Baltimore Md.

0 NAME OF FATHER Sam Smith

1 BIRTHPLACE OF FATHER (city or town) (State or country) Winston-Salem, N.C.

2 MAIDEN NAME OF MOTHER Mary Vanderburg

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Winston-Salem, N.C.

Informant (Address) Records of City Hospitals

Filed 7-30 1930 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1930, to July 26, 1930, that I last saw him alive on July 26, 1930, and that death occurred, on the date stated above, at 7:55 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic, rheumatic.

(duration) 1 yrs. moe de.

CONTRIBUTORY (Secondary) Auricular fibrillation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. history.

(Signed) Paul Padget, M. D.

7-27 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashley Cemetery July DATE OF BURIAL 30 1930

20 UNDERTAKER Blue, T. W. Johnson 416 N. Carey ADDRESS

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59327

CERTIFICATE OF DEATH.

90 E 59327

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 Sargent ST 21-24 WARD)

2-FULL NAME George W. Galloway

(a) RESIDENCE NO. 1202 Selgent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Anna Galloway

DATE OF BIRTH (month, day, and year) July 4, 1858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	72.	0	24.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 31

(b) General nature of industry, business, or establishment in which employed (or employer) B. O. R. R.

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Wm. Galloway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Sarah A. Galloway.

(Address) 1202 Sargeant St.

1930 ..., 19 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to July 28, 1930, that I last saw h[illegible] alive on July 28, 1930, and that death occurred, on the date stated above, at 6.45 P. m. Daylight.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Straus, M. D.

7/28. 1930 (Address) 1901 Griffith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL July 31 1930.

20 UNDERTAKER M. Inus. John W. Teufel & Son — ADDRESS 501 W. Fayette St.

c.—1-30—M. & T.—250 Blks. Aksel Aarum.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59328

CERTIFICATE OF DEATH.

21 E 59328

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE: (No. Church Home Infirmary St. 1568 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aksem Aarum

(a) RESIDENCE NO. 1614 Thames St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 15 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

f married, widowed, or divorced HUSBAND of or) WIFE of Grace Aarum

ATE OF BIRTH (month, day, and year) Sept. 4, 1895

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
4		10	25	

CUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer) Navigation

(c) Name of employer

IRTHPLACE (city or town) (State or country) Norway

0 NAME OF FATHER Johnson

1 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

2 MAIDEN NAME OF MOTHER Johnson

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

Informant Grace Aarum

(Address) 1614 Thames

JUL 30 1930 J. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29. 1930

17

I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 29, 1930, that I last saw him alive on July 29, 1930, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos da.

CONTRIBUTORY (Secondary) alcoholism

(duration) 19 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) M. M. Elgin, M. D.

7-29, 1930 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 7/31 1930

UNDERTAKER Wilhem Loch

ADDRESS 1219 E Fayette

c.—1-30—M. & T.—250 Bks.

E 59329

HEALTH DEPARTMENT—CITY OF BALTIMORE

148/E 59329

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. Sinai Hospital ST. 2-4 WARD)

2-FULL NAME Mrs. Dorothy Brown

(a) RESIDENCE NO. 2018 East Pratt ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
ength of residence in city or town where death occurred 20 yrs. X mos. X ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
~~HUSBAND of~~ WIFE of Elon. Edgar Brown

ATE OF BIRTH (month, day, and year) Nov 27 1905

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	8	1	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

IRTHPLACE (city or town) Bible Dorchester Co
(State or country) Md

0 NAME OF FATHER Estrae O. Albers

1 BIRTHPLACE OF FATHER (city or town) Dorchester Co
(State or country) Md

2 MAIDEN NAME OF MOTHER Rosa Mills

3 BIRTHPLACE OF MOTHER (city or town) Dorchester Co
(State or country) Md

Informant William E. Brown

(Address) 2018 E. Pratt St. Phys. MD

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1930

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to July 28, 1930, that I last saw him alive on July 28, 1930, and that death occurred, on the date stated above, at 8 30 A. m.

The CAUSE OF DEATH* was as follows:

Eclampsia
Post Partum

(duration) ..... yrs. ..... mos. 3/4 ds.

CONTRIBUTORY (Secondary) Eclampsia - Post Partum
(duration) ..... yrs. ..... mos. 3/4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Ritchie Robert Cohen, M. D.

7/28 1930 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Church Creek Md Via B & A

DATE OF BURIAL July 30, 1930

20 UNDERTAKER John F. Denny

ADDRESS 710 Light St

c.—1-30—M. & T.—250 Rks

E 59330 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 59330

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO.) 23-31 ST. (WARD)

2-FULL NAME Roland Fontz

(a) RESIDENCE NO. 1308 Hanover St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 56 yrs. 0 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Ma	White	single

f married, widowed, or divorced HUSBAND of or) WIFE of

ATE OF BIRTH (month, day, and year) July 16 - 1874

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	0	11	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk at 9

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Baltimore Md.
(State or country)

0 NAME OF FATHER Henry Fontz

1 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

2 MAIDEN NAME OF MOTHER Henrietta Johnson

3 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

Informant Mrs. Fontz Wife
(Address)

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27/30

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1930, to 7/27/30, 19...,

that I last saw h alive on 7/27/30, 19...,

and that death occurred, on the date stated above, at 8 a.m. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-Ray - Sputum Exam.

(Signed) David Tenner, M. D.

7/27/30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill 6m

DATE OF BURIAL 7/30 1930

20 UNDERTAKER J. F. McCully

ADDRESS 130 E. Fort

e 1930 C. HAMPSON JONES, M. D.

Cor.—12-9-25—A Co.—200 Blks.

Thomas Leroy Smith

HEALTH DEPARTMENT—CITY OF BALTIMORE

199 E 59331

E 59331

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 24-33 Ward

2-FULL NAME Thomas Leroy Smith

(a) RESIDENCE NO. 132 E. Fort Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 6 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 7 1920

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	10	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

10 NAME OF FATHER Charles Smith

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Grace Burton

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Mrs. Charles Smith

(Address) 1328 Baltimore Ave

15 Filed ....., 19 C. HUNTER JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto tire blew out causing driver to lose control collision with another auto & then continuing on running down Client

(Duration) yrs. mos. ds.

CONTRIBUTORY Fract Skull Fract Radius & Ulna L

(Duration) yrs. mos. ds.

(Signed) H. Frame M. D.

(Coroner)

(Address) 5939 Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not At place of death? Wash Blvd

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial 7/31 1930

20 UNDERTAKER I. Few McCully ADDRESS 1306 E. Fort

...—1-30—M. & T.—250 Blks

59332 HEALTH DEPARTMENT—CITY OF BALTIMORE D 59332

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

TY OF BALTIMORE: (No. Provident Hospital 16-23 100 ST. (or) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Nelson

(a) RESIDENCE NO. 825 N Calhoun ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
nale	colored	single

married, widowed, or divorced HUSBAND of (or) WIFE of

ATE OF BIRTH (month, day, and year) Sept 7, 1929

GE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10	22	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) Balto

(State or country) Md

NAME OF FATHER Christopher Nelson

BIRTHPLACE OF FATHER (city or town)

(State or country) Va

MAIDEN NAME OF MOTHER Estella Ennis

BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

Informant Christopher Nelson

(Address) 825 N Calhoun

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29-30

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1930, to July 29, 1930,

that I last saw h.r alive on July 29, 1930,

and that death occurred, on the date stated above, at 7 30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Primary)

(duration) yrs. about 10 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M St Clair, M. D.

7-29, 1930 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 7-30 1930

20 UNDERTAKER Wm. H. Chase Sons

ADDRESS 400 Madison

0 1930 C. HAMPSON JONES, M. D. Registrar

c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59333

CERTIFICATE OF DEATH.

57E 59333

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 3506 Trait ave ST., 7637 WARD)

2-FULL NAME Margaret Hufnagel

(a) RESIDENCE NO. 3506 Trait ave ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

f married, widowed, or divorced HUSBAND of or) WIFE of Michael Hufnagel

ATE OF BIRTH (month, day, and year) April 29th 1866

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64	3	29	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Germany

0 NAME OF FATHER Ludwig Rosenberger

1 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

2 MAIDEN NAME OF MOTHER ?

3 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

Informant Michael Hufnagel

(Address) 3506 Trait ave

Filed JUL 30 1930, 19 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28/30

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to July 28, 1930,

that I last saw her alive on July 27, 1930,

and that death occurred, on the date stated above, at 8 15 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pneumonitis (duration) yrs. 10 mos. ds.

18 Where was disease contracted, if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) Horace B. Tilden, M. D.

7/29, 1930 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug. 1st 1930
UNDERTAKER J. Lilly + Zeiler Inc	ADDRESS 403 S. [illegible] St

c.—1-30—M. & T.—250 Blks.

E 59334

59334 HEALTH DEPARTMENT—CITY OF BALTIMORE

114

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 507 S. Kenwood Ave. St. 12 WARD)

2-FULL NAME Dorothy M. E. Tischer

(a) RESIDENCE NO. 507 S. Kenwood Ave St. 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

married, widowed, or divorced HUSBAND of or) WIFE of Christian T. Tischer

ATE OF BIRTH (month, day, and year) May 9th 1873

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	2	19	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, usiness, or establishment in hich employed (or employer) at Home

(c) Name of employer

RTHPLACE (city or town) Balto. Md.
(State or country)

NAME OF FATHER Gustav Laupus

BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

MAIDEN NAME OF MOTHER Eliz Griebel

BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

Informant Christian T. Tischer

(Address) 507 S. Kenwood ave

Filed JUL 30 1930 H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1930, to July 28, 1930, that I last saw her alive on July 28, 1930, and that death occurred, on the date stated above, at 8:05 a. m.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency -

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mucous Colitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X. Ray - Physical exam

(Signed) Louis F. Krumeich, M. D.

, 19 (Address) 722 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Laurel Cemetery

DATE OF BURIAL July 31 1930

20 UNDERTAKER Lilly + Feiler Inc.

ADDRESS 403 S. Wolfe St.

c.—1-30—M. & T.—250 Bks.

59335

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59335

CERTIFICATE OF DEATH.

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE (No.) 2108 Eagle St. 20-12 WARD)

2-FULL NAME Reinhold A. Stranz

(a) RESIDENCE NO. 2108 Eagle ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

married, widowed, or divorced
HUSBAND of
or) WIFE of Hedwig Stranz

ATE OF BIRTH (month, day, and year) July 14 1861

GE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	69	—	14	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Ind Acft

(c) Name of employer Apt Co

RTHPLACE (city or town) Germany
State or country)

NAME OF FATHER August Stranz

BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

MAIDEN NAME OF MOTHER Margaretha Meuser

BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Hedwig Stranz
(Address) 2108 Eagle St.

G. HARRISON JONES, M.

Registrar

30 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28/30

17

I HEREBY CERTIFY, That I attended deceased from June 28, 1930 to July 28, 1930

that I last saw h[illegible] alive on July 28, 1930

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Enginia Pectoris

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Hypertension

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly M. D.

7/31/30 (Address) 1127 W Cead St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 7/30/30

UNDERTAKER H. A. Shepherd

ADDRESS 1850 W. Baltimore St

c.—3-29-28—L. F. S.—500 Blks.

E 59336

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59336

CERTIFICATE OF DEATH

194

1—PLACE OF DEATH

REGISTERED NO. 76-37

CITY OF BALTIMORE: (No. 1310 S. Bayliss ST. (or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Holewinski

(a) RESIDENCE NO. 1316 S. Bayliss ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-29-30

7 AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

10 NAME OF FATHER: Andrew Holewinski

BIRTHPLACE OF FATHER (city or town) (State or country): Germany

MAIDEN NAME OF MOTHER: Anna Rosel

BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

Informant: Mrs. Anna Holewinska

(Address) 1310 S. Bayliss Av

Filed 7-30 1930 H. L. BLACK JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29-30

17 I HEREBY CERTIFY, That I attended deceased from 7-29- 1930, to 7-29 1930, that I last saw him alive on 7-29- 1930 and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Heat Exhaustion

(duration) 2:30 hrs yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 12 hrs. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. B. Bromwich, M. D.

7-30 1930 (Address) 3037 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: July 30 1930

20 UNDERTAKER: J. M. Rozewicz

ADDRESS: 1930 Eastern

c.—1-30—M. & T.—250 Blks.

239229

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59337 JOHNS HOPKINS HOSPITAL

CERTIFICATE OF DEATH.

90 E 59337

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ST., 2-4 WARD)

2-FULL NAME Paul Szurzynski

(a) RESIDENCE NO. 2235 Hoffe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

married, widowed, or divorced HUSBAND of or) WIFE of Ellis

ATE OF BIRTH (month, day, and year) Dec 17 1879

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
√T	50	3	11	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

RTHPLACE (city or town) (State or country) Poland

NAME OF FATHER Stern

BIRTHPLACE OF FATHER (city or town) (State or country) Poland

MAIDEN NAME OF MOTHER Anna (?)

BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant Records JOHNS HOPKINS HOSPITAL

(Address) C. HARVEY JONES, M. D.,

Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-28-1930

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1930, to July 28, 1930, that I last saw him alive on July 28, 1930, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Osteosarcoma-femur

Carcinomatosis

Uremia

(duration) several [redacted] ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) several mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Hedwig Koessig, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary July	31 1930
UNDERTAKER	ADDRESS
J M Rosenthal - 1930	Baltimore

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

59338

CERTIFICATE OF DEATH

194 ✓ E 59338

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Pier (— Pratt St. & 25 WARD)

2-FULL NAME John Shepphard Shepphard

(a) RESIDENCE No. 679 W. Madison St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Sheppard

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 46			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): B.C. & G. Co
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Va

16 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Nellie Sheppard

(Address) 679 W Madison St

Filed 1930 C. H. Reuth Jones, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29-30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intoxication

Acute (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. T. Riley, M. D. Coroner

July 29 19 30 (Address) 06 39 Brunswick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 7/31 1930

UNDERTAKER: Samuel Easton

ADDRESS: 916 Pa Ave

c.—1-30—M. & T.—250 Blks.

239136
E 59339

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 59339
REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 17-26 ST. (WARD)

2-FULL NAME Frank Miller

(a) RESIDENCE NO. 507 Ogston ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
ngth of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	black	married

f married, widowed, or divorced HUSBAND of or) WIFE of Lena

ATE OF BIRTH (month, day, and year) March 10-1902

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	4	17	

CCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

RTHPLACE (city or town) (State or country) S.C

0 NAME OF FATHER Grant Miller

1 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

2 MAIDEN NAME OF MOTHER Minnie Warren

3 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

Informant Relative
(Address) Johns Hopkins Hospital

Filed 1930 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27-1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 27, 1930, that I last saw him alive on July 27, 1930, and that death occurred, on the date stated above, at 5-40 p. m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Uremia
(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Blood Chem
(Signed) Hedley Rawing, M. D.
7/27, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL July 30, 1930

UNDERTAKER Mrs Kate R Williams — ADDRESS 3224 Schroeder St.

c.—2-29-28—L. F. S.—500 Bks.

E 59340

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 59340

1—PLACE OF DEATH

REGISTERED NO. 2755

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.) 5319 Denmon (STREET) (WARD)

2—FULL NAME Joseph Fagan

(a) RESIDENCE NO. 5319 Denmon Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) 1905

E	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
25				

CUPATION OF DECEASED

) Trade, profession or rticular kind of work Presser

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) Baltimore City
tate or country) Maryland

NAME OF FATHER Unknown

BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

MAIDEN NAME OF MOTHER Rosa Fagan

BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

Informant William C. Brooks Sister-in-law

(Address) 5319 Denmon Ave

30 1930 C. HARRISON JONES, M.
19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29/30

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to July 29, 1930, that I last saw h— alive on July 29th, 1930 and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

6

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Allen W White-L, M. D.

, 19 (Address) 2600 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Aug 1 — 1930
UNDERTAKER	ADDRESS
Jno Lobe & H. Bailey	1922 Jeffer

...—8-16-29—L. F. S.—100 Bks.

E 59341

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 59341

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 913 S. Decker ST. 1-1 WARD)

2—FULL NAME Frank J. Kaftka

(a) RESIDENCE NO. 913 S. Decker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	white	Widowed

married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kaftka

TE OF BIRTH (month, day, and year) Not known

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

CUPATION OF DECEASED

) Trade, profession or articular kind of work Iron Moulder

) General nature of industry, siness, or establishment in hich employed (or employer) 047

) Name of employer

RTHPLACE (city or town) State or country) Austria

NAME OF FATHER Vaclav Kaftka

BIRTHPLACE OF FATHER (city or town) (State or country) Austria

MAIDEN NAME OF MOTHER Not known

BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

Informant Catherine Kaftka

(Address) 913 S. Decker a

Filed JUN 30 1930 C. HAMPSON JONES, Registrar, By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29/30

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to July 29, 1930, that I last saw him alive on July 29, 1930, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Metastatic Pleuropneumonia

(duration) yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Bronchopneumonia

Nephritis. (duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Microscopic

(Signed) M. Schneider, M. D.

7/29, 30 (Address) 330 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 31 1930

20 UNDERTAKER ADDRESS

Fidelity Burial Co Inc 1906 Gaylord

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59342

CERTIFICATE OF DEATH

99 E 59342

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 924 Pear ST. 17-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Palmer

(a) RESIDENCE NO. 924 Pear. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed or Divorced (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of No

DATE OF BIRTH (month, day, and year) 1898

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Saleslady.
(b) General nature of industry, business, or establishment in which employed (or employer): 041
(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: John Palmer

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Frances Trazon

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Co Md

Informant: Anna Houston

(Address): 501 Lanvale

Filed 1930 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Stomach Intestinal Hemorrhage Acute Dilatation of heart Sudden

Contributory (Secondary) Worked and Beating (duration) yrs. Sudden

18 Where was disease contracted if not at place of death? 924 Pear.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

(Signed) [illegible], M. D. Coroner

July 30 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: July 30 1930

20 UNDERTAKER: Samuel Beasley

ADDRESS 378 N Bridle

Spec.—1-10-21—M&T—1500 Bks.

E 59343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 59343

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1007 E. Biddle St. (ST.) 10-1 (WARD)

2-FULL NAME Frederick Seibold.

(a) RESIDENCE NO. 1007 E. Biddle St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Seibold.

DATE OF BIRTH (month, day, and year) Sept. 12.1854

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	10	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police Sergt.

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer Balto. City Police Dept.

BIRTHPLACE (city or town) (State or country) Baltimore Md,

10 NAME OF FATHER Henry Seibold.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

Informant (Address) Mrs Catherine Seibold. 1007 E. Biddle St.

Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29th 1930

17 I HEREBY CERTIFY, That I attended deceased from August 1929 to July 29 1930 that I last saw h[illegible] alive on July 28 1930 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - chronic

Myocarditis - Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) F. J. Kirby, M. D.

7/30 1930 (Address) 1110 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL Aug. 1st. 30

UNDERTAKER Chas. E. Sauerhöfer

ADDRESS 1180 Mt Royal ave

0 1930

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59344

E 59344

CERTIFICATE OF DEATH.

REGISTERED NO. 70694

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1033 S. Catherine ST., 70 (WARD)

2-FULL NAME Mrs. Anna E. Hausmann

(a) RESIDENCE NO. 1033 S. Catherine ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick Hausmann

7 DATE OF BIRTH (month, day, and year): Oct. 22-1880

8 AGE — Years: 49 — Months: 9 — Days: 7 — If LESS than 1 day, ... hrs. or ..... min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 237

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Balto., Md

11 NAME OF FATHER: Ferdinand Kosloski

12 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

13 MAIDEN NAME OF MOTHER: Caroline Klaus

14 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

Informant: Miss Marie E. Hausmann

(Address) 1033 S. Catherine St.

JUL 30 1930 C. HAMPSON JONES, M. D. Registrar

Dat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1930

17 I HEREBY CERTIFY, That I attended deceased from ..... 29 ..... 19 ..... to July 29 19 30,

that I last saw h[illegible] alive on July 29 19 30,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 1 yrs. 4 mos. 25 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of Operation 1/29

Was there an autopsy? .....

What test confirmed diagnosis? Operative findings & X-Ray

(Signed) James R. Kazmeyer M.D.

7/30 1930 (Address) 1729 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: July 31 1930

20 UNDERTAKER: George L. Lohmeyer — ADDRESS: 1101 Park Ave.

c.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59345 ✓

E 59345

CERTIFICATE OF DEATH.

129

REGISTERED NO. 165

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.) 1813 Carmine Ave. ST., 28 WARD)

2-FULL NAME Florence M. Lucas

(a) RESIDENCE NO. 1813 Carmine Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

eegth of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. A. Lucas

ATE OF BIRTH (month, day, and year) March 15, 1883

GE	Years	Months	Days	If LESS than 1 day, ..hrs. or min.
	47	4	13	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Md.

0 NAME OF FATHER George Keck

1 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

2 MAIDEN NAME OF MOTHER Barbara Bell

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Wm. A. Lucas

(Address) 1813 Carmine Ave.

Filed 1930 C. HAMPSON JONES, M. D. Registrar

By C.H.J.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1930

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to July 28 1930

that I last saw her alive on July 25, 1930

and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows: Uraemic Convulsions

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Nephritis (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. Y. Eversfield M. D.

7/29/30 (Address) 1400 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park Cemetery	July 31 1930
20 UNDERTAKER	ADDRESS
John J. Denny	715 Light St.

c.—2-20-26—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59346 ✓ E 59346

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

TY OF BALTIMORE: (No. 1630 Normal ave ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Hecker

(a) RESIDENCE NO. 1630 Normal ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

f married, widowed, or divorced HUSBAND of (or) WIFE of Henry Hecker

ATE OF BIRTH (month, day, and year) Apr. 27-1850

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	3	2	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

IRTHPLACE (city or town) (State or country) Germany

0 NAME OF FATHER Conrad Weisbrod

1 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

2 MAIDEN NAME OF MOTHER Eva Elfenline

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. Eva Hecker Daughter

(Address) 1630 Normal ave

30 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29-1930

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1930, to July 29, 1930,

that I last saw her alive on July 28, 1930

and that death occurred, on the date stated above, at 1135a m.

The CAUSE OF DEATH* was as follows:

Hypertension, Arteri Sclerosis
Uraemia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uraemia

(Signed) Thos. F. Stearns, M. D.

7/30, 1930 (Address) 2878 Halford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 1 1930
20 UNDERTAKER	ADDRESS
John F Denny	715 Light St

Cor.—10-10-29—A Co.—100 Blks.

E 59347

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59347

CERTIFICATE OF DEATH

185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Balto City Hospital (Ward) No. 3

2-FULL NAME Frederick George Herbert

(a) RESIDENCE NO. Townsend Rd St., Essex Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn Herbert

6 DATE OF BIRTH (month, day, and year) Dec 7th 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	28	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer) Harry B. Hull Co

(c) Name of employer

BIRTHPLACE (city or town) Balto City

(State or country)

10 NAME OF FATHER Adam Herbert

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Annie Schenker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto City

Informant Evelyn Herbert

(Address) Townsend Rd Essex

Filed ..... 19 .....

C. HAMPSON JONES, Registrar

L 30 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) and that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture 3rd & 4th Cervical Vertebrae accidental

(duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) during Shaking work at Middle River Shore (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Middle River Shore

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) James M Hamilton M. D.

7-30-1930 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Aug 1st 1930
20 UNDERTAKER John G. Connelly	ADDRESS Essex

c.—1-30—M. & T.—250 Blks

E 59348

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59348

CERTIFICATE OF DEATH.

34

1-PLACE OF DEATH Baltimore City Hospitals (T.B. 27)

TY OF BALTIMORE: (No. ..... ST. 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Jordan

(a) RESIDENCE NO. 705 W. Franklin st. ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

ngth of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Colored	Single

f married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) 1901 ?

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
29	28 ?			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

IRTHPLACE (city or town) (State or country) North Carolina

0 NAME OF FATHER Arthur Jordan

1 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

2 MAIDEN NAME OF MOTHER Emma Holly

3 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

Informant Hospital Records

(Address)

01930 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1929, to July 25, 1930,

that I last saw him alive on July 25, 1930,

and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous osteomyelitis of spine

(duration) Unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Paraplegia

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) David Seaver, M. D.

7-25 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL July 31, 1930

20 UNDERTAKER Joseph A. Luff & Son — ADDRESS 1710 Pennsylvania Ave

30—M. & T.—100 B—50L

E 59349

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3171 E 59349

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST., WARD X

2-FULL NAME Ludwig Buttinas

(a) RESIDENCE NO. Carondelet Apts. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 21 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clothes Peddler
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) austria

10 NAME OF FATHER Frank Buttinas

11 BIRTHPLACE OF FATHER (city or town) (State or country) austria

12 MAIDEN NAME OF MOTHER Dant Emma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) austria

Informant Frank Mozzla

(Address) Carondelet Apts W Pa

C. HAMPSON JONES, M. D. Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above. Edward Mills Glass

The CAUSE OF DEATH* was as follows:

Suicide

Shooting R.S. Rock cutting Jugular vein (duration) ..... yrs. ..... mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. C. Glass, M. D. Coroner

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richwood W Va	7/30/30 19
20 UNDERTAKER Joseph Ahrens	ADDRESS 221 Bway

c.—1-30—M. & T.—250 Bks

E 59350

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59350

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 2017 Kelly Ave ST., 27.W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Gwynn

(a) RESIDENCE NO. 2017 Kelly Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 4 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Colored	Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Gwynn

ATE OF BIRTH (month, day, and year) 11. 8. 1857

GE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
?	73	8	21	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Soldier 86

(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Army

(c) Name of employer

IRTHPLACE (city or town) (State or country) Maryland

0 NAME OF FATHER Joshua Gwynn

1 BIRTHPLACE OF FATHER (city or town) (State or country) Md

2 MAIDEN NAME OF MOTHER Margaret Ellen Cook

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Louisa Gwynn

(Address) 2017 Kelly Ave.

Filed 1930 C. HAMPSON JONES, M. D. Registrar

Per ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7. 29. 1930

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1926, to July 29, 1930, that I last saw h.im alive on July 28, 1930, and that death occurred, on the date stated above, at 12.20 a. m.

The CAUSE OF DEATH* was as follows: Arterio Sclerosis - Paralysis of left side for 1 year Chronic Bright's Disease Mitral Regurgitation

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) C. H. Beeler, M. D.

7.29, 1930 (Address) 1st Washington Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	July 31 1930
UNDERTAKER	ADDRESS
Geo. H. Holland	1512 D. St.

...—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 59351

E 59351

REGISTERED NO.

1—PLACE OF DEATH

TY OF BALTIMORE: (No. Woman's Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen A. Nicholson

(a) RESIDENCE NO. 2817 N. Calvert ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

rth of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) Aug. 18, 1867

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	11	12	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work at home

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

THPLACE (city or town) Richmond
tate or country) Indiana

NAME OF FATHER John Nicholson

BIRTHPLACE OF FATHER (city or town) Wayne
(State or country) Indiana

MAIDEN NAME OF MOTHER Mary B. ?

BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Indiana

Informant Mrs. A. M. Carey

(Address) Freeway & E. Monument Sts.

Filed 1930 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 30, 1930 that I last saw h.e.r alive on July 30, 1930 and that death occurred, on the date stated above, at 2 20 P m. (D.L.S.T.)

The CAUSE OF DEATH* was as follows:

Right Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of bladder (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Rudolph J. Schork M. D.

. 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery | DATE OF BURIAL Aug 1 1930

UNDERTAKER Standard Woman's Co | ADDRESS Balto

Spec—12-23-21—E.B.R.S.—400 Bks.

E 59352

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59352

CERTIFICATE OF DEATH.

90 16

1-PLACE OF DEATH

City of BALTIMORE: (No. 412-E-31st St., 12th Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Jane Mills

(a) Residence No. 412-E-31 St., 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? 70 yrs. 4 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

6-If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert Mills

7-DATE OF BIRTH (month, day and year) March 3 1860

8-AGE, 70 yrs. 4 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

9-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

BIRTHPLACE (city or town) Salto (State or Country), Md.

10-NAME OF FATHER Isaac Morris

11-BIRTHPLACE OF FATHER (city or town) Salto (State or Country), Md.

12-MAIDEN NAME OF MOTHER Susan J. Rowley

13-BIRTHPLACE OF MOTHER (city or town) Salto (State or Country) Md

(Informant) Mrs Florence M. McClure

(Address) 412-E-31-St City

Filed 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 28/30

17- I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to July 28, 1930, that I last saw h alive on July 28, 1930, and that death occurred, on the date stated above, at 8.0 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hay Fever Adults

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Chas. C. Hamner M. D.

19 (Address) 4724 York Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery — DATE OF BURIAL, July 31, 1930

20-UNDERTAKER. Stewart & Co — ADDRESS Salto

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59353

74-001 ✓ E 59353

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2348 Woodbrook ave St., 15-21 Ward)

2-FULL NAME Mary M Engle

(a) RESIDENCE NO. 2348 Woodbrook ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Oct 3rd 1858

8 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	71	9	26	

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

10 BIRTHPLACE (city or town) Balto
(State or country) Md

11 NAME OF FATHER Geo. Engle

12 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

13 MAIDEN NAME OF MOTHER Unknown

14 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

15 Informant Mrs. Carl Lewis
(Address) 2348 Woodbrook ave

Filed 7 30 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

7/30/30 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL 7/31 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul st

.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59354

CERTIFICATE OF DEATH

123 E 59354

REGISTERED NO.

—PLACE OF DEATH

TY OF BALTIMORE: (No. Maryland General Hospital ST. W. N. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME William T. Lamb

a) RESIDENCE NO. 411 E. Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

th of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

married, widowed, or divorced
HUSBAND of
(or) WIFE of

TE OF BIRTH (month, day, and year) Aug 19-1868

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	11	11	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work Machinist

) General nature of industry, siness, or establishment in hich employed (or employer) G.M.

) Name of employer

THPLACE (city or town) Georgetown
tate or country) D. C.

NAME OF FATHER Joseph A. Lamb

BIRTHPLACE OF FATHER (city or town) D. C.
(State or country)

MAIDEN NAME OF MOTHER Hannah Loretto

BIRTHPLACE OF MOTHER (city or town) Trenton
(State or country) N. J.

Informant Hospital records.
(Address)

C. HAMPSON JONES, M. D.
Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 30

17 I HEREBY CERTIFY, That I attended deceased from 7-xx-, 1930, to 7-30-, 1930, that I last saw h.i.m alive on 7-30, 1930 and that death occurred, on the date stated above, at 10. a.m. D.T.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis
Cholelithiasis
?
(duration) 1 yrs. ? mos. ?

CONTRIBUTORY (Secondary) Acute dilatation of Heart
(duration) yrs. mos. ds. ?

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 7-xx-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert V. Cenowitz, M. D.

, 19 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 8/1/ 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

c.—1-12-23—M&T—500 Blks.

59355

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 59355

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 522 N Bradford ST., 6-10 WARD)

2-FULL NAME Mary E Hatus

(a) RESIDENCE No. 522 N. Bradford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	Widowed

married, widowed, or divorced HUSBAND of (or) WIFE of Jot Hatus

ATE OF BIRTH (month, day, and year) ? 1850

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
70		?		

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Md

0 NAME OF FATHER Richard Marine

1 BIRTHPLACE OF FATHER (city or town) (State or country) Md

2 MAIDEN NAME OF MOTHER Unknown

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Clarence Cooper

(Address) 522 N Bradford St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1930

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 30, 1930,

that I last saw h— alive on July 30, 1930,

and that death occurred, on the date stated above, at 4:50 p.m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Sen. Nephritis - Old age

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) W. L. Reilly, M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashley Amity DATE OF BURIAL July 31 1930

UNDERTAKER R. E. Wilkerson ADDRESS Mt Clare

0-1930 . 19 C. HAMPSON JONES, M. D. Registrar

c.—1-30—M. & T.—250 Blks.

E 59356

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59356

31

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 150 N. Haven ST., 2637 WARD)

2-FULL NAME Mrs. Ida Seidengahl

(a) RESIDENCE NO. 150 N. Haven St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem'l	White	Married

married, widowed, or divorced
HUSBAND of
01) WIFE of Thomas H. Seidengahl

TE OF BIRTH (month, day, and year) 1—19—1901

GE Years	Months	Days	If LESS than 1 day hrs. or min.
29 yrs.	6	10	

CCUPATION OF DECEASED

a) Trade, profession or particular kind of work Housewife

b) General nature of industry, business, or establishment in which employed (or employer) 137

c) Name of employer

RTHPLACE (city or town) Balto.
State or country) Md.

NAME OF FATHER John H. Sparr

BIRTHPLACE OF FATHER (city or town) Wilmington
(State or country) Del.

2 MAIDEN NAME OF MOTHER Stuart

BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

Informant John S. Sparr
(Address)

C. HAMPSON JONES, M. D.
Registrar

0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29/30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1929, to July 29, 1930,

that I last saw her alive on July 29, 1930,

and that death occurred, on the date stated above, at 11,05 9. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) H. Carrington Faught M. D.

, 19 (Address) 2942 Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 8/2/30

UNDERTAKER Geo. J. Ruth Inc.

ADDRESS 1930 Hoby

C.—1-30—M. & T.—250 Bks.

7392 88
E 59357
152

HEALTH DEPARTMENT—CITY OF BALTIMORE E 59357

CERTIFICATE OF DEATH.

REGISTERED NO. 152

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) ST., 27-44 WARD)

2-FULL NAME Margaret Lobes

(a) RESIDENCE No. 5918 Leyton Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): —

If married, widowed, or divorced (h) HUSBAND of (or) (w) WIFE of —

DATE OF BIRTH (month, day, and year) June 4 1929

AGE: Years | Months: 1 | Days: 25 | If LESS than 1 day, ...hrs. or ....min.: Twelfth

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER George Lobes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant (Address) JOHNS HOPKINS HOSPITAL

Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29-30

17 I HEREBY CERTIFY, That I attended deceased from 7-26, 1930, to 7-29, 1930, that I last saw h[illegible] alive on 7-29, 1930, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Staphylococcus Septicaemia

(duration) ....yrs. ....mos 24 ds.

CONTRIBUTORY (Secondary) Furunculosis

(duration) ....yrs. ....mos. 24 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood culture.

(Signed) J. W. Bickford, M. D.

7/30 1930 Address Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 7/31/1930.

20 UNDERTAKER George J. Ruth Inc

ADDRESS 1731 Hanford

c.—1-30—M. & T.—250 Blks.

E 59358 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59358

CERTIFICATE OF DEATH. 159-00

1-PLACE OF DEATH
TY OF BALTIMORE: (No.) U. of M. Baltimore General Hospital (If not in hospital, give street and number.)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Reechel

(a) RESIDENCE NO. Millersville, Md ST., Rt. 33 WARD
(Usual place of abode) (If non-resident give city or town and State)
ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	white	Single

married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) 7/26/30

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) South Bolts Factory
(State or country) Baltimore Md

0 NAME OF FATHER Otto Reechel

1 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

2 MAIDEN NAME OF MOTHER Florence Humphreys

3 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

Informant
(Address)

F 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29-30

17 I HEREBY CERTIFY, That I attended deceased from 7-26, 1930, to 7-29, 1930
that I last saw him alive on 7-29, 1930,
and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Congenital Heart Disease (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign

(Signed) Joseph Leibowitz, M. D.

, 19 (Address) South Baltimore Gen'l Hosp. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL , 19

UNDERTAKER

ADDRESS

JUL 30 1930

E 59359 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59359

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 7 1 REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.....ST., ...WARD)

2-FULL NAME Rachel Dillard

(a) RESIDENCE NO. 116 S. Bond ST., ...WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

ATE OF BIRTH (month, day, and year) March 8 ?

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42	4	18	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

RTHPLACE (city or town) New Market
(State or country) Md.

0 NAME OF FATHER Edward Hall

1 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

2 MAIDEN NAME OF MOTHER Mary Bruce

3 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

Informant Records of
(Address) Balto. City Hosp.

Filed ....., 19..... C. HAMPSON JONES, M. D.
Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26-30

17 I HEREBY CERTIFY, That I attended deceased from 7-16-30, 19....., to 7-26-30, 19.....,
that I last saw h.er alive on 7-26-30, 19.....,
and that death occurred, on the date stated above, at 4:15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus with metastasis to liver and lung

(duration) Unknown

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ....yrs. ....mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Fred M. Dunkerly M. D.
, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

UNDERTAKER Commissioner of Health.

ADDRESS

JUL 3 01930

c.—1-30—M. & T.—250 Blks

E 59360 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59360

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ST., 11-24 WARD)

2-FULL NAME Joseph Neal

(a) RESIDENCE NO. 1004 Dryid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 1.fe yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single.

married, widowed, or divorced HUSBAND of (or) WIFE of —

ATE OF BIRTH (month, day, and year) unknown.

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
65?	—	—	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dishwasher

(b) General nature of industry, business, or establishment in which employed (or employer) ? 086

(c) Name of employer ?

RTHPLACE (city or town) Baltimore (State or country) Md.

0 NAME OF FATHER Wm Neal

1 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

2 MAIDEN NAME OF MOTHER Martha ?

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Records of Hospitals

(Address) BALTIMORE CITY HOSPITALS

Filed 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1930, to July 26, 1930, that I last saw h[illegible] alive on July 26, 1930, and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Syphilis of central Nervous Syst. (duration) UNKNOWN. yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. Wassermann.

(Signed) Paul Padget, M. D.

7-27, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

JUL 30 1930

c.—1-30—M. & T.—250 Blks.

E 59361

E 59361 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59361

CERTIFICATE OF DEATH. 16-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. St. Joseph's Hospital ST., 8-17 WARD)

2-FULL NAME Charles Meyers.

(a) RESIDENCE NO. 1800 N. Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	S

f married, widowed, or divorced
HUSBAND of
or) WIFE of —

ATE OF BIRTH (month, day, and year) May 22-1930

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	7	

CCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

RTHPLACE (city or town) Balto
(State or country)

0 NAME OF FATHER Chas Meyers

1 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

2 MAIDEN NAME OF MOTHER Theresa Sumner

3 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

Informant Chas Meyers

(Address) 1235 N Eutaw St

Filed ....., 19..... H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1930.

17 I HEREBY CERTIFY, That I attended deceased from
7-25, 1930, to 7-29, 1930.

that I last saw h[illegible] alive on 7-29, 1930,

and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical manifestations

(Signed) M B Dunning, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL Aug. 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

1930

C.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59362 — 90 E 59362

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2803 Orleans ST., 6-11 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Rudloff

(a) RESIDENCE NO. 2803 Orleans ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Rudloff

6 DATE OF BIRTH (month, day, and year) Apr 23 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	3	5	

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

8 BIRTHPLACE (city or town) (State or country) Balto

9 NAME OF FATHER — Bollrath

10 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

11 MAIDEN NAME OF MOTHER — Hertle

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

13 Informant Mrs Chas F Schreibel
(Address) 2803 Orleans St

Filed 1930

C. H. [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28-1930

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to July 28, 1930, that I last saw her alive on July 28, 1930 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:
Arteriosclerotic Cardio-vascular disease

not known (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? N V Date of —

Was there an autopsy? N V

What test confirmed diagnosis? Physical Exam

(Signed) C P Rosling, M. D.

, 19 (Address) 1811 W. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem — DATE OF BURIAL Jul 31 1930

20 UNDERTAKER John Ulrich — ADDRESS 2803 Orleans

E 59363

E 59363

STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County

Village or City Baltimore (No. 303 Lorraine ave E St. 12 Ward) Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Harry C. Trout

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Sept 5, 1866 (Month) (Day) (Year)

7 AGE: 64 yrs. 10 mos. 24 ds. If LESS than 1 day ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed or (employer):

9 BIRTHPLACE (State or country): Balto Co Md

10 NAME OF FATHER: Jacob Trout

11 BIRTHPLACE OF FATHER (State or country): Penna

12 MAIDEN NAME OF MOTHER: Mandelia Shewey

13 BIRTHPLACE OF MOTHER (State or Country): Carroll Co Md

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roman Trout

(Address) Owings Mills Md

Filed 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July 29, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 1 1930 to July 29, 1930, that I last saw him alive on July 29, 1930, and that death occurred on the data stated above, at 9.50 p.m.

The CAUSE OF DEATH * was as follows:

Chr. Myocarditis
Arteri - Sclerosis

Unknown (Duration) ... yrs. ... mos. ... ds.

Contributory Secondary Dropsy, Cardiac Insufficiency (Duration) ... yrs. 6 mos. ... ds.

(Signed) Milton P. Bell M. D.

July 30 1930 (Address) 4531 Reisterstown Rd

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Luthern Cemetery Reisterstown	Aug 1, 1930
20 UNDERTAKER	ADDRESS
J F Elsino & Sons	Reisterstown

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

md

c.—1-30—M. & T.—250 M.

E 59364

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

59361

166 E 59364

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) University Hospital ST., 4-30 WARD X

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marian Thawley

(a) RESIDENCE NO. Crisfield Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 20 yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	W.	S.

f married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) Dec 5-1900

GE	Years	Months	Days	If LESS than 1 day, hr. or min.
	29	7	25	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Librarian

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Public Library

RTHPLACE (city or town) Crisfield Md
(State or country)

0 NAME OF FATHER John W. Thawley

1 BIRTHPLACE OF FATHER (city or town) Burnsville
(State or country) Md

2 MAIDEN NAME OF MOTHER Annie Cochran

3 BIRTHPLACE OF MOTHER (city or town)
(State or country) Conn

Informant B B Thawley
(Address) Crisfield Md

Filed ..... 19 C. E. JONES, M. D., Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1930

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1930, to July 30, 1930, that I last saw h.r alive on July 30, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bichloride of mercury poisoning (acute) over

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) George H. Yeager, M. D.

7/30, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL*	DATE OF BURIAL
Crisfield Md	Aug 2 1930
UNDERTAKER	ADDRESS
John A Bradshaw	Crisfield

086 Eugene Zeller d. Oct 20 1930 Clk.

c.—1-30—M. & T.—250 Blks

59365 HEALTH DEPARTMENT—CITY OF BALTIMORE 91-002 E 59365

CERTIFICATE OF DEATH. REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO. 717 E 34th ST., 9-47 WARD)

2-FULL NAME Mary J. Sullivan

(a) RESIDENCE NO. 717 E. 34th ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widow

married, widowed or divorced HUSBAND of or) WIFE of Timothy Sullivan

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Ireland

0 NAME OF FATHER John Gearty

1 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

2 MAIDEN NAME OF MOTHER Bridget Gearty

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mary N. Sullivan
(Address) 717 E 34th St.

Filed 7/31 1930 Registrar

1-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/30/30

17 I HEREBY CERTIFY, That I attended deceased from 7/27, 1930, to 7/30, 1930, that I last saw h alive on 7/29, 1930, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Senility
Uremia (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wirth, M. D.
7/31, 1930 (Address) 1216 E Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Aug 1, 1930

20 UNDERTAKER Rita Wiedefeld — ADDRESS 914 Greenmount Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 59366

59366

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 225 S. Stricker ST., 19-28 WARD)

2-FULL NAME Mary F. Duvall

(a) RESIDENCE NO. 225 S. Stricker ST., 19 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed or divorced HUSBAND of (or) WIFE of Joseph R. Duvall

DATE OF BIRTH (month, day, and year)

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Howard Co. Md.

10 NAME OF FATHER Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md

12 MAIDEN NAME OF MOTHER Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md

Informant Rose F. Stander

(Address) 225 S. Stricker St

Filed 1-1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1930

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1930, to July 29, 1930, that I last saw h e alive on July 23, 1930, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) — yrs. — mos. 27 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) J. A. Buchmen, M. D.

, 19 (Address) 37 S. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Howard Co. Md. Richland Cem.

DATE OF BURIAL July 31st 1930

20 UNDERTAKER A. Jones

ADDRESS 111 S. Gilmor

c.—1-30—M. & T.—250 Blks.

135299 E 59367

HEALTH DEPARTMENT—CITY OF BALTIMORE E 59367

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE, (No. 14.23 ST., WARD)

2-FULL NAME Isaac White

(a) RESIDENCE No. 1352 Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	black	married

If married, widowed, or divorced
HUSBAND of
or) ~~WIFE of~~ Nellie

ATE OF BIRTH (month, day, and year) unknown

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	-	-	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work cook

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

RTHPLACE (city or town) (State or country) Md.

0 NAME OF FATHER Robert

1 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

2 MAIDEN NAME OF MOTHER Catherine Parker

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant (Address) JOHNS HOPKINS HOSPITAL

Filed 1930, 19 ROBT. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29-30

17

I HEREBY CERTIFY, That I attended deceased from 3-27, 1930, to 7-29, 1930,

that I last saw h~~e~~ alive on 7-29, 1930,

and that death occurred, on the date stated above, at 1 00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Prostate

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 18-1930

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 8/1 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1503 Presstman St

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 59368 X 144 E 59368

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) Mercy Hospital ST., 47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edythe Hailer

(a) RESIDENCE NO. 214 Church Lane, Pikesville Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

f married, widowed, or divorced HUSBAND of (or) WIFE of Birch A. Hailer

ATE OF BIRTH (month, day, and year) Nov 4 1896

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	8	26	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) General 037

(c) Name of employer Self

IRTHPLACE (city or town) Baltimore

State or country) Maryland

0 NAME OF FATHER Harry L. French

1 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

2 MAIDEN NAME OF MOTHER Catherine Collins

3 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

Informant Birch A Hailer

(Address) 214 Church Lane Pikesville Md

Filed 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30/30.

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1930, to July 30, 1930, that I last saw her alive on July 30, 1930, and that death occurred, on the date stated above, at 6:20 a. m.

The CAUSE OF DEATH* was as follows:

Pregnancy at term

Labor

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Post Partum Hemorrhage

(duration) 9 hours yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Mercy Hospital

Did an operation precede death? No Date of None

Was there an autopsy? None

What test confirmed diagnosis? Clinical Signs only

(Signed) Edward L Smith, M. D.

7/30, 1930 (Address) 920 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL 8-2 1930

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Holl

c.—1-30—M. & T.—250 Bks.

E 59369

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59369

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 3916 Bateman Ave ST., 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Schwartzman

(a) RESIDENCE NO. 3916 Bateman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	female white	married

d married, widowed or divorced HUSBAND of or) WIFE of Rev. Hyman Schwartzman

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

IRTHPLACE (city or town) (State or country) Russia

0 NAME OF FATHER Hyman Shochet

1 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

2 MAIDEN NAME OF MOTHER Gross

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Louis

(Address) 1739 Bank St

Filed 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30th 30

17 I HEREBY CERTIFY, That I attended deceased from June, 19 30, to July 30, 19 30, that I last saw h[er] alive on July 30, 19 30, and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic myocarditis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & Lab.

(Signed) Leider D. Levy M. D.

July 1930 (Address) 2324 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Beth Tefilath Cong. Windsor Mill

DATE OF BURIAL Jul 7-31- 19 30

20 UNDERTAKER Jack Levin, 1439 E Baltimore St,

ADDRESS

Spec. 1-10-21 MA 1 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59370 E 59370

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 223 N. Port St ST., 1-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose J. Connelly

(a) RESIDENCE NO. 223 N. Port St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

6 If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of James L. Connelly

DATE OF BIRTH (month, day, and year) May 9, 1898

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	2	20.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Adam P. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Minnie Rubran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant James L. Connelly

(Address) 223 N. Port St

Filed 1-1930 H. Hampton Jones, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 28, 1930, that I last saw h~~e~~r alive on July 28, 1930, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Frank J. Ayd, M. D.

July 30, 1930 (Address) 2045 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Aug 1 1930

20 UNDERTAKER Frank V. Pipitone

ADDRESS 2818 E. Balto

c.—1-30—M. & T.—250 Blks

E 59371

E 59371 HEALTH DEPARTMENT—CITY OF BALTIMORE

129

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 604 S. Broadway ST., 2-4 WARD)

2-FULL NAME Anniela Hepner

(a) RESIDENCE NO. 604 S. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Widow

married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Michal Hepner Not Known

ATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
bout	62	0	0	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home 037

(c) Name of employer

IRTHPLACE (city or town) (State or country) Germany.

0 NAME OF FATHER Jos. Bochenski

1 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

2 MAIDEN NAME OF MOTHER Mary Dolla

3 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

Informant Stanislaus Hepner

(Address) 604 S. Broadway

Filed 1 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 29, 1930.

that I last saw h[illegible] alive on July 28, 1930,

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

Uremia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Terminal Broncho Pn

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 7

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Chem

(Signed) E. H. Pond Jr., M. D.

7/30 1930 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 8/2 1930

UNDERTAKER William Fiaschowdy

ADDRESS 1618 Eutaw

...—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 59372

E 59372 REGISTERED NO.

...—PLACE OF DEATH

TY OF BALTIMORE: (No. 1434 E Fayette ST., 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

...—FULL NAME Jerry Brown

(a) RESIDENCE NO. 1434 E. Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

...th of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

...	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

married, widowed, or divorced
HUSBAND of (or) WIFE of Laura Brown

...TE OF BIRTH (month, day, and year)

...E	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	32			

...CUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O.H.D.

(c) Name of employer

...THPLACE (city or town) (State or country) Md

NAME OF FATHER Wm Shaw Brown

BIRTHPLACE OF FATHER (city or town) (State or country) Md

MAIDEN NAME OF MOTHER Unknown

BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Laura Brown

(Address) 1434 E Fayette St

Filed ... 1930, 19...

...C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 - 30

17 I HEREBY CERTIFY That I attended deceased from July 14, 1930, to July 29, 1930, that I last saw h...d alive on July 28, 1930 and that death occurred, on the date stated above, at 2 30 ...m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Acquired (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Influenza Pneumonia (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Edward Fisher, M. D.

7-30 1930 (Address) 1642 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury cemetery	aug 1 1930
UNDERTAKER Edward Borgen	ADDRESS 1636 Orleans St

c.—1-30—M. & T.—250 Blks

E 59373 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. X 49 E 59373

1-PLACE OF DEATH Union memorial Hospital 9-47 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Willard G. Rouse

(a) RESIDENCE NO. Easton Maryland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. 9 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Widowed

f married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) April 12th 1864.

GE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	3	19	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Maryland
(State or country)

0 NAME OF FATHER John G. Rouse

1 BIRTHPLACE OF FATHER (city or town) Maryland.
(State or country)

2 MAIDEN NAME OF MOTHER Harriet B. Keen

3 BIRTHPLACE OF MOTHER (city or town) Maryland.
(State or country)

Informant Hospital Records
(Address)

Filed 9-1 1930 H. [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 31st July 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 14th, 1929, to July 31st, 1929,

that I last saw him alive on July 31st, 1930,

and that death occurred, on the date stated above, at 10-35 a.m. daylight saving time.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

over

(duration) yrs. 9 mos 17 da.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Date of 10/26/29

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) Richard T. Shandrewood, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Abingdon M.E. Cemetery

DATE OF BURIAL Aug 1 1930

20 UNDERTAKER Howard K. McCoomer

ADDRESS Abingdon Md.

c.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59374

E 59374

CERTIFICATE OF DEATH.

REGISTERED NO. 78

1-PLACE OF DEATH Baltimore City Hospls. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO.) Baltimore St., Md 2x.6 (WARD)

2-FULL NAME Irwin Jones

(a) RESIDENCE NO. 106 W. York St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced; (write the word)
ale	Black	Single

married, widowed, or divorced HUSBAND of (or) WIFE of

ATE OF BIRTH (month, day, and year) Unk

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
5-				

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) (State or country) Maryland

NAME OF FATHER Unknown

BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

MAIDEN NAME OF MOTHER Unknown

BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records (Address) Balto City Hospls

Filed 1-1 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29-30

17 I HEREBY CERTIFY, That I attended deceased from 6-21-, 1929, to 7-29, 1930, that I last saw living on 7-28, 1930, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion

Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Epileptic Psychosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy Findings

(Signed) Harry J. Obrien, M. D.

7/29 1930 (Address) Baltimore City Hospls

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion

DATE OF BURIAL July 31 1930

ADDRESS Norwood Montgomery Co

20 UNDERTAKER J. S. Brown & Son

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59375

CERTIFICATE OF DEATH

90 E 59375

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pier No.8

City of Baltimore: (No. Port Covington. St. 23-31 Ward)

2-FULL NAME George Cephart.C. or Andrew Treadwell.(C)

(a) RESIDENCE NO. 110 N.Henrietta St, St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ---------- How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	41	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer) W.Md.R.R.Co.
(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina.
(State or country)

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

Informant John Riley.(C)
(Address) 9 N.Church St.

Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.
Coronary Sclerosis.
Acute dilatation of the Heart.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquiry.

(Signed) [illegible], M. D.

7/31, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion

DATE OF BURIAL July 31 1930

20 UNDERTAKER J. L. Brown & Son

ADDRESS 1121 W. Montgomery St

HARRY JONES, M. D. Registrar

1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59376

CERTIFICATE OF DEATH

194 E 59376

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1820 Gough St., W. Ward)

2-FULL NAME Henry Richard McCarthy

(a) RESIDENCE NO. 1820 Gough St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Dec 8/1869

8 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
60	60	7	20	

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) in Boat
(c) Name of employer Retired U.S. Navy

BIRTHPLACE (city or town)
(State or country) Canada

10 NAME OF FATHER McCarth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

Informant U.S. Veterans Bureau
(Address) Fort McHenry

Filed 1930 19 C. HARRISON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to H S death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Prostration

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) General Debility

(duration) 1 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

7-31-1931 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL 7/31/1930

20 UNDERTAKER Harry A Wiltze

ADDRESS 4101 Edmondson

c.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

59377

90 E 59377

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 1330 N. Stricker ST., 14-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Cromwell

(a) RESIDENCE NO. 1330 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

married, widowed, or divorced HUSBAND of or) WIFE of

ATE OF BIRTH (month, day, and year) 1866

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) (State or country) Centreville Md

0 NAME OF FATHER Benedy Bryan

1 BIRTHPLACE OF FATHER (city or town) (State or country) Md

2 MAIDEN NAME OF MOTHER Lydia Hollis

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Lena Johnson

(Address) 1330 N. Stricker St

Filed 8-1 1930 H. Polk Jones, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to July 29, 1930, that I last saw h[illegible] alive on 7-29-30, and that death occurred, on the date stated above, at 4-35 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 3 mos. wks da.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? 1330 Stricker

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M Boykin, M. D.

(Address) 1512 N. Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md

DATE OF BURIAL 7/31 1930

UNDERTAKER Samuel Tabeuley

ADDRESS 398 E Biddle

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59378 ✓

E 59378

46

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 122 S. East Ave. ST., 16-2 WARD)

2-FULL NAME AGNES JACKSON

(a) RESIDENCE NO. 122 S. East Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Widowed

f married, widowed, or divorced HUSBAND of (or) WIFE of Charles M. Jackson

ATE OF BIRTH (month, day, and year) Jan. 8 1853

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	6	22	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Baltimore, (State or country) Md.

0 NAME OF FATHER Robert Barker

1 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

2 MAIDEN NAME OF MOTHER Anna Cannon

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

Informant Lee Jackson

(Address) 122 S. East Ave.

Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 30

17 I HEREBY CERTIFY, That I attended deceased from May 6, 30, to July 29, 1930,

that I last saw h-1 alive on July 29, 1930,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.

Pelvic Organ.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ages,

Did an operation precede death? no Date of 1929.

Was there an autopsy? no

What test confirmed diagnosis? clinical symptoms

(Signed) A Kent Turley, M. D.

7-30-1930 (Address) 2738 E Baltd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cem.

DATE OF BURIAL Aug. 2 1930

UNDERTAKER George W. Zibler

ADDRESS 1737 E. Eager st

Spec.—1-10-21—M&T—1500 Blks.

59379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4301 Reisterstown Rd 14-001

E 59379

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Kirkleigh Villa ST. 13-5-3 WARD)

2-FULL NAME Ruby Gertrude Dart

(a) RESIDENCE No. Kirkleigh Villa ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) July 4 1858

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	—	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Va.

10 NAME OF FATHER John Dart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass

12 MAIDEN NAME OF MOTHER Elizabeth Hannah

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

Informant (Address) Jos. A. Dart 611 Floyd Ave Richmond Va

Filed 1-1930 H. H. Kerr Jones, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1930

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to July 30, 1930.

That I last saw h alive on July 30 1930

and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 7 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of —

Was there an autopsy? none

What test confirmed diagnosis? clinical

(Signed) Vernon D Tilley M. D.

7/31, 1930 (Address) 606 Somerset Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond Va — DATE OF BURIAL: July 31 1930

UNDERTAKER: Chas. T. Trice & Son — ADDRESS: 1 W Mt Royal Ave

...ec.—1-12-23—M&T—500 Blks.

E 59380

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59380

CERTIFICATE OF DEATH

1-PLACE OF DEATH Jenkins Memorial Hospital 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1000 Caton Ave. ST., 20 71 WARD)

2-FULL NAME Mrs. Mary Amanda Banks

(a) RESIDENCE NO. 645 Haw St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

If married, widowed, ~~or divorced~~ ~~HUSBAND OF~~ (or) WIFE OF: Frank W. Banks

DATE OF BIRTH (month, day, and year)

December

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
79 yrs.			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): D 31

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Wilmington Delaware

10 NAME OF FATHER: James A. Gebhard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Devine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

Informant (Address): Jenkins Memorial Hosp. 1000 Caton Ave

Filed 1930 . 19 . HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30, 1930

17

I HEREBY CERTIFY, That I attended deceased from August 1, 1927, to July 30, 1930, that I last saw her alive on July 30, 1930, and that death occurred, on the date stated above, at 2:35 P. m.

The CAUSE OF DEATH* was as follows:

Congestive heart failure with Pulmonary Edema.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocardial degn. (duration) Dev'd yrs. mos. ds.

If Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) H. A. Hamerson M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Aug 2nd 1930

UNDERTAKER: Mary A Gaughan

ADDRESS: 2839 Ramsay

c.—1-30—M. & T.—250 Blks.

E 59381 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59381

X 100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

TY OF BALTIMORE: (No. N. Carlton & Lafayette ST. 9-17 WARD)

2-FULL NAME Bertha Lee O'Connor

(a) RESIDENCE NO. Bentley Quarters ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
ale	White	Single

f married, widowed, or divorced HUSBAND of (or) WIFE of

ATE OF BIRTH (month, day, and year) aug 13-1927

GE	Years	Months	Days 16	If LESS than 1 day, ...hrs. or ....min.
	2	11	13	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Baltimore Maryland

0 NAME OF FATHER Maurice A. O'Connor

1 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

2 MAIDEN NAME OF MOTHER Jessie M. Schwab

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Maurice A. O'Connor

Address Bentley Quarters Md.

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 26th, 1930, to July 29th, 1930, that I last saw h.. alive on July 29th, 1930, and that death occurred, on the date stated above, at 5 35 0 m.

The CAUSE OF DEATH* was as follows:

Encephalitis (Multiform Type)

(duration) yrs. mos 3 da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. H. Hendrix, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL aug 1st 1930

UNDERTAKER Mary D. Gaulthaf

ADDRESS 2839 Ravenwood Ave

E 59382 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59382

CERTIFICATE OF DEATH. 74-001

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2421 Guilford Av (St.) (Ward)

2-FULL NAME Hattie Maud Mohrlein

(a) RESIDENCE (Usual place of abode) No. 2421 Guilford Av St. 12 Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? 60 yrs. 2 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

If married, widowed, or divorced (HUSBAND of or) WIFE of Geo. F. Mohrlein

6 DATE OF BIRTH (month, day, and year) May 10 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (City or town) (State or country) Port Deposit Maryland

10 NAME OF FATHER Abraham Frist

11 BIRTHPLACE OF FATHER (city or town) Union Bridge (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Meyers

13 BIRTHPLACE OF MOTHER (city or town) Union Bridge (State or country) Maryland

Informant (Address) Geo. F. Mohrlein (Husband) 2421 Guilford Av

Filed 7-1 1930 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-30-30

17 I HEREBY CERTIFY, That I attended deceased from 7/24/30, 19..., to 7/30, 1930, that I last saw h... alive on 7/30, 1930, and that death occurred, on the date stated above, at ... P ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Weiss, M. D.

7/31 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lauderdale Cemetery	Aug 2, 1930
UNDERTAKER	ADDRESS
Stewart Mortuary	Balto

C.—1-30—M. & T.—250 Blks.

E 59383 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

E 59383

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST. 7 8-63 129 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L McNamara

(a) RESIDENCE NO. Lynchburg Va. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Feb. 2. 1874

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	5	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mattress business

(b) General nature of industry, business, or establishment in which employed (or employer) Own 145

(c) Name of employer Own

BIRTHPLACE (city or town) Lynchburg
(State or country) Virginia

10 NAME OF FATHER William L. McNamara

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Joana Morton

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Ireland

Informant Mt Hope Retreats
(Address) Mt Hope Retreat

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from March, 1930, to July 30, 1930, that I last saw him alive on July 30, 1930, and that death occurred, on the date stated above, at 8.15 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Arteriosclerosis

Unknown (duration) — yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency
(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical • Physical

(Signed) Milton P. Hill, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lynchburg Va.	Aug 1 '30.
20 UNDERTAKER	ADDRESS
Stewart McDonald	Baltimore

c.—1-30—M. & T.—250 Blks

E 59384

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59384

74-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 3016 Oak Hill ave ST., 9-16 WARD)

2-FULL NAME Harry Lee Hoffman

(a) RESIDENCE NO. 3016 Oak Hill ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 60 yrs. 10 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	white	Single

f married, widowed, or divorced HUSBAND of (or) WIFE of —

ATE OF BIRTH (month, day, and year) Sept 26 1869

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	60	10	4	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Baltimore
(State or country) Md

0 NAME OF FATHER John Hoffman

1 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

2 MAIDEN NAME OF MOTHER Lavinia Hartzell

3 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

Informant Herbert H. Prechsler

(Address) 3016 Oak Hill ave

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30/30

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to July 30, 1930, that I last saw h[illegible] alive on July 29, 1930, and that death occurred, on the date stated above, at 7-30 a.m. Standard Time

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. M. Lumpkin, M. D.

July 31 1930 (Address) 3409 Callaway ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Aug 1 1930

20 UNDERTAKER Chas. H. Black — ADDRESS 1420 W. North ave

c.—1-30—M. & T.—250 Blks.

E 59385

E 239142
E 59385

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO. 13-52 ST., WARD)

2-FULL NAME Jacob Hann

(a) RESIDENCE NO. 1421 Marling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) July 11-1930

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	—	17	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Md
(State or country)

0 NAME OF FATHER Jacob Hann

1 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

2 MAIDEN NAME OF MOTHER Anna Coost

3 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

Informant JOHNS HOPKINS HOSPITAL Records
(Address)

Filed JUL 31 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-28-1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 28, 1930, that I last saw him alive on July 28, 1930, and that death occurred, on the date stated above, at 6 10 P m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? None.

(Signed) R. O. Warren, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUL 31 1930

1930

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59386

CERTIFICATE OF DEATH.

46 E 59386

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 517 N Carrollton St. 18-76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Myrick

(a) Residence No. 517 N. Carrollton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fe

4-COLOR OR RACE, Col

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (Write the word.) Widow

6-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Myrick

7-DATE OF BIRTH (month, day and year) 1876

8-AGE, 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

9-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Own Home

(c) Name of employer

10-BIRTHPLACE (city or town) (State or Country), Virginia

10-NAME OF FATHER Peter Myrick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Betty Parham

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14-(Informant) Lee Bryant

(Address) 517 N. Carrollton

15-Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 29, 1930

17-I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930, to July 29, 1930, that I last saw her alive on July 29, 1930, and that death occurred, on the date stated above, at 12:10 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Garland Chappell M. D.

1930 (Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mount Auburn Cemetery — DATE OF BURIAL, August 2, 1930

20-UNDERTAKER, John H Queen — ADDRESS 5-38 Dolphin St

c.—1-30—M. & T.—250 Bks.

E 59387

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59387

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH St. Josephs Hospital.

TY OF BALTIMORE: (No. Caroline & Oliver St. ST., 24-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys Smith

(a) RESIDENCE NO. 308 E. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 23 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

f married, widowed, or divorced HUSBAND of or) WIFE of Mr. Theodore Smith

ATE OF BIRTH (month, day, and year) Nov. 7, 1901

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
23	7 8	24	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

IRTHPLACE (city or town) Baltimore Md.
(State or country)

0 NAME OF FATHER Harmon Zimmerman

1 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

2 MAIDEN NAME OF MOTHER Mary Zimmerman

3 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

Informant Mr. Theodore Smith.
(Address) 308 E. Hamburg St.

Filed 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 31, 1930, that I last saw her alive on July 31, 1930, and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Cancer Ovaries

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Thyroidectomy

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 7, 1930

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) N B Worthington M. D.

(Address) 1412 Eutaw Place, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Hill Cem	Aug 2 19
20 UNDERTAKER A. Howard Evans	ADDRESS 28 S. Eutaw St

.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59388 — REGISTERED NO. 117 — E 59388

—PLACE OF DEATH

TY OF BALTIMORE: (No. Md. General Hospital ST., WARD) 28-66 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

—FULL NAME Mrs Catherine E. Cline

(a) RESIDENCE NO. 4403 Roseby Rd ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

rth of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
White	Married

married, widowed or divorced

HUSBAND of (or) ~~WIFE~~ of Ralph. L. Cline

TE OF BIRTH (month, day, and year) June 7, 1895

E	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	1	24	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work Housewife

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer

RTHPLACE (city or town) Baltimore
tate or country) Md.

NAME OF FATHER Chas. L. Cline

BIRTHPLACE OF FATHER (city or town) Frederick. Md
(State or country)

MAIDEN NAME OF MOTHER Nora Wright

BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

Informant Hospital records.
(Address)

Filed ... 1930 ... HAMPSON JONES, M. D.
... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31-1930

17 I HEREBY CERTIFY, That I attended deceased from 7-15-, 1930, to 7-31, 1930, that I last saw her alive on 7-31, 1930 and that death occurred, on the date stated above, at 3:20 a.m. S.T.

The CAUSE OF DEATH* was as follows:

Subacute appendicitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Dilatation of Heart (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 7-16-30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert V. Clemmitt, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL Aug 2 1930

20 UNDERTAKER Wm J Tuckner Sons

ADDRESS N. Ave

E 59389 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 59389

122-001

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Genl Hos St.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Mahn 21-29

Residence in Baltimore: No. 1006 Ridgely St.; yrs. 35 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Single

6-DATE OF BIRTH. Dec 6 1894
(Month) (Day) (Year)

7-AGE. 35 yrs. 7 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Furniture moving
(b) General nature of Industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER. Frank Mahn

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Amelia Lennenger

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Mahn

(Address) 1006 Ridgely St

Filed 1930 H. BAKER JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 29 1930
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sclerosis of Liver
Coronary Sclerosis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Right Renal Calculus
(Duration) mos. ds.

(Signed) H. Leech M. D.
July 30 192 (Address) Coroner

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
London Park Aug. 1 1930

20-UNDERTAKER. Wm J Luckner Sons ADDRESS N. Y. Ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 59390

REGISTERED NO. E 59390

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 59390

1-PLACE OF DEATH

City of Baltimore: (No. 182 W. Hughes St. St., Ward)

2-FULL NAME Annie Wright. (C) 22-31

(a) RESIDENCE NO. 182 W. Hughes St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) September 15, 1904

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	25	10	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER Matthew Wright. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Minnie Ward. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

Informant Matthew Wright. (C) father.
(Address) 51 E. Hughes St.

Filed 1930 19 C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

7/29, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leakey Cemetery

DATE OF BURIAL 8/1/30

20 UNDERTAKER E. Wallace

ADDRESS 515 N. Eden St

Spec.—1-10-21—MAT—1500 Blks.

E 59391 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 59391

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1723 E. Preston St. ST., WARD) E-17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pattie Olivia Wilson

(a) RESIDENCE NO. 1723 E. Preston St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

6 If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Abija Howard Wilson

DATE OF BIRTH (month, day, and year) October 31. 1882

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	9	0	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ebenezer Miss

10 NAME OF FATHER William Kiellebrew

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Miss.

12 MAIDEN NAME OF MOTHER Sally ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Miss.

Informant Abija Howard Wilson

(Address) 1723 E. Preston

Filed 1-7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1930

17 I HEREBY CERTIFY, That I attended deceased from April 15 1930, to July 31 1930, that I last saw her alive on July 30 1930, and that death occurred, on the date stated above, at 5. a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Lab. Findings

(Signed) Chas Wilbur Stewart, M. D.

7/31, 1930 (Address) 1738 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Aug 2 1930

20 UNDERTAKER J. Henry Lutz ADDRESS 1205 N. Broadway

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59392

CERTIFICATE OF DEATH

143-001 E 59392

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., Ward)

2-FULL NAME Agnes Fitze

(a) RESIDENCE NO. Mt. Airy, Md. St., 4-30 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1-1912

7 AGE: Years 17 | Months 8 | Days 30 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House-work
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

10 NAME OF FATHER Casper Fitze

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Soldie Spencer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant (Address)

Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

1 - 1930 -

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis secondary to an abortion (one)

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D.

8/1, 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Krebs Cem. Carroll Co. Md

DATE OF BURIAL: Aug. 3 1930

20 UNDERTAKER: H. M. Snyder

ADDRESS: Mt Airy

Spec.—1-10-21—M&T—1500 Bks.

E 59393

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59393

CERTIFICATE OF DEATH.

194

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1221 Mosher ST., ... WARD)

2-FULL NAME David W. Grosh

(a) RESIDENCE NO. 1221 Mosher ST. 16-23 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	C	Married.

a If married, widowed, or divorced HUSBAND of (or WIFE of) Martha Grosh

DATE OF BIRTH (month, day, and year) uncertain.

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	approx 62	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber yard.

(b) General nature of industry, business, or establishment in which employed (or employer) — 86

(c) Name of employer —

BIRTHPLACE (city or town) Balto Md.
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

Informant Mrs Viola Cooke (daughter)
(Address) [illegible] Mosher St

Filed ..... 19 .....

T-1950 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1930

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to July 31, 1930.

that I last saw him alive on July 30, 1930

and that death occurred, on the date stated above, at 3:20 A.m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis Parenchymatous

(duration) ..... yrs. Comp mos. ..... da.

CONTRIBUTORY (Secondary) Heart Exhaustion and Pneumonia

(duration) ..... yrs. ..... mos. 5 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. T. Upman M. D

(Address) 1214 E Monument St

7/31, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Aug 2 1930
20 UNDERTAKER Samuel D. Heneley	ADDRESS 678 Waddle

c.—1-30—M. & T.—250 Blks.

E 59394

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59394

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 514 N. Carey ST., WARD) 19-26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wilson

(a) RESIDENCE NO. 514 N. Carey ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

ngth of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X: ale

4 COLOR OR RACE: Colored

5 Single, Married, Widowed or Divorced, (write the word): Married

married, widowed, or divorced HUSBAND of or) WIFE of: Deroschia Wilson

ATE OF BIRTH (month, day, and year): 1874

GE	Years	Months	Days	LESS than 1 day, ... hrs. or ..... min.
	56			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

RTHPLACE (City or town) (State or country): Cape May N.J.

0 NAME OF FATHER: John Wilson

1 BIRTHPLACE OF FATHER (city or town) (State or country): N.J.

2 MAIDEN NAME OF MOTHER: Wilson

3 BIRTHPLACE OF MOTHER (city or town) (State or country): N.J.

Informant: Deroschia Wilson

(Address): 514 N. Carey St.

1 - 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29/30

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to July 29, 1930, that I last saw him alive on July 28, 1930, and that death occurred, on the date stated above, at 10-30 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. F. Neville, M. D.

8/4/1930 (Address) 601 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Aug 1 1930

UNDERTAKER: Samuel Hensley

ADDRESS: 2128 E. Eddle

c.—1-30—M. & T.—250 Bks.

E 59395 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59395

CERTIFICATE OF DEATH.

70

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. Sinai Hospital ST., WARD)

2-FULL NAME Fannie Kahn

(a) RESIDENCE NO. Marlborough Apts- ST., 14-20 WARD

(Usual place of abode)

(If non-resident give city or town and State)

ength of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

f married, widowed, or divorced HUSBAND of or) WIFE of —

ATE OF BIRTH (month, day, and year) May 18, 1865

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	2	13	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) Balto. (State or country) Md.

0 NAME OF FATHER Aaron Kahn

1 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

2 MAIDEN NAME OF MOTHER Ida Goldsmith

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Miss. Tillie Kahn

(Address) Marlborough Apts

FILED 1 - 1936 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1930

17

I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to July 31, 1930, that I last saw h[illegible] alive on July 31, 1930, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) ....yrs. ....mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Nelson Blount, M. D.

, 19 (Address) Owings Mills Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Beth Shalom Cem.

DATE OF BURIAL 8/1/1930

20 UNDERTAKER Edward Sondheimer Son

ADDRESS 1902 Eutaw Place

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59396 102 E 59396

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) J H Hospital ST., ... WARD)

2-FULL NAME Infant Smith

(a) RESIDENCE NO. 573 S Caroline ST., 3-4 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

DATE OF BIRTH (month, day, and year) June 2 1929

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		13	28	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John E Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Alice Wagner

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Baltimore Md

Informant Alice L Smith

(Address) 573 S Caroline St

C. THOMPSON JONES, M. D.

Filed JUL 30 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 19 30

17 I HEREBY CERTIFY, That I took Charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) ..... yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) Acute Laryngitis

(duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted if not at place of death? 573 S Caroline

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Exp atm

(Signed) C T O'Donnell Jr, M. D.

Coroner

, 19 (Address) 143 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwandts Cem	Aug 2 19 30
20 UNDERTAKER Kindell & Lippard	ADDRESS 2000 Eden

c.—1-30—M. & T.—250 Blks

59397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 E 59397

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

TY OF BALTIMORE: (No. ..... ST., ... WARD) 5-9

2-FULL NAME John T. Mears

(a) RESIDENCE NO. 1404 Orleans ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Colored	Married

married, widowed, or divorced HUSBAND of (or) WIFE of Mary Mears

ATE OF BIRTH (month, day, and year) Sept. 1, 1883

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	10	28	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) 004

(c) Name of employer

RTHPLACE (city or town) Northampton

(State or country) Va.

0 NAME OF FATHER George

1 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

2 MAIDEN NAME OF MOTHER Unknown

3 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

Informant Records of

(Address) Balto. City Hosp.

Filed 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29-30

17

I HEREBY CERTIFY, That I attended deceased from 6-30-30, 19..., to 7-29-30, 19..., that I last saw him alive on 7-29-30, 19..., and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) ... yrs. 7 mos ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padget, M. D.

7-30, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Aug 1 1930

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 825 [illegible]

Spec.—1-10-21—M&T—1500 Bks.

59398

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59398

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 716 N. Monroe St. ST., WARD) 16-22

2-FULL NAME Catherine Hanf.

(a) RESIDENCE NO. 716 N. Monroe St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

6 If married, widowed, or divorced

(or) WIFE of Gottlieb Hanf.

DATE OF BIRTH (month, day, and year) January 2, 1847

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	6	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

10 NAME OF FATHER Henry Gruen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Rebecca Amrein.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

Informant Matilda Hanf. (daughter)

(Address) 716 N. Monroe St.

Filed 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31st. 1930

17

I HEREBY CERTIFY, That I attended deceased from March, 1929, to July 31, 1930,

that I last saw her alive on July 31, 1930,

and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Arterio sclerosis.

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage,

Hemiplegia. (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnisis.

(Signed) Otto M. Reinhardt L. M. D.

8/1, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Pauls Violettville.

DATE OF BURIAL Aug 2 1930

20 UNDERTAKER George M. Little

ADDRESS 2700 Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59399

CERTIFICATE OF DEATH

90 E 59399

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1115 Peach Alley. St., Ward) 23-31

2-FULL NAME Charles Caldwell. C.

(a) RESIDENCE NO. 1115 Peach Alley. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Widower

6a If married, widowed, or divorced
HUSBAND of Jennie Caldwell. C.

7 DATE OF BIRTH (month, day, and year) Do not know.

8 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	44	---	---	

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) O+C
(c) Name of employer

BIRTHPLACE (city or town) Pennsylvania.
(State or country)

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

Informant Della Brightfoot C.
(Address) 1115 Peach Alley.

Filed 1930 C. ILLWOOD JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardiat Insufficiency.

Acute dilatation of the Heart.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Chas. H. Reinhardt, M. D.

8/1, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion	Aug 1 1930
20 UNDERTAKER	ADDRESS
S. A. Brown's Son	108 N. Howard

c.—1-30—M. & T.—250 Blks

E 59400 ✓ E 59400

HEALTH DEPARTMENT—CITY OF BALTIMORE

155

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

2-FULL NAME Bertie Mae Winkler

(a) RESIDENCE NO. 2021 Harford Rd ST., 27-43 WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
...ale	white	Single

f married, widowed, or divorced HUSBAND of (or) WIFE of

ATE OF BIRTH (month, day, and year) Oct 4

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	9	26	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) (State or country) Balto Md

0 NAME OF FATHER Albert

1 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

2 MAIDEN NAME OF MOTHER Claire Bannister

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Hospital Records (Address)

C. HAMPSON JONES, M. D. Registrar

Filed ...1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-30-30

17 I HEREBY CERTIFY, That I attended deceased from 2-21-, 1930, to 2-30, 1930, that I last saw h[er] alive on 2-30, 1930, and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis 12 dorsal vertebra

(duration) ....yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Staphylococcus aureus Septicaemia

(duration) ....yrs. ....mos. 7+ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-22-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical + operat.

(Signed) J Zeyko, M. D.

2/30, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

UNDERTAKER L. J. Rusch

DATE OF BURIAL 2/V 1930

ADDRESS 5 Eutaw

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59401

CERTIFICATE OF DEATH

159-002

E 59401

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 846 S. Sharp St. St., Ward) 22-31

2-FULL NAME Dorsey.(C)

(a) RESIDENCE NO. 846 S. Sharp St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 30, 1930- 8.30 a.m.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	----------	----------	----------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER John Ross.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Helen Dorsey.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Helen Dorsey.(C) mother
(Address) 846 S. Sharp St.

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar
1-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2.30 p.m. July 30 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Nitrat Insufficiency.

over

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Altenstaedt, M. D.

8/1, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL Aug 1 1930

20 UNDERTAKER Walter B. Phipps

ADDRESS 739 W Hamburg St

...—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 59402

E 59402

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto. Gen. Hosp. ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Hankofsky

(a) RESIDENCE NO. 224 S. Bond ST. 3-4 WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis

DATE OF BIRTH (month, day, and year): 1878

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	52			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 039

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

Informant: Louis

(Address): 1439 E. Balto. St.

Filed 1-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1930

17

I HEREBY CERTIFY, That I attended deceased from July 31, 1930, to Aug 1, 1930,

that I last saw her alive on Aug 1, 1930,

and that death occurred, on the date stated above, at 4:40 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ...yrs. ...mos 9 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) ...yrs. ...mos. 1 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harold H. Eshman M. D.

, 19 (Address) W. Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: North Point - Herman Hill Cem.

DATE OF BURIAL: 8-1-1930

UNDERTAKER: Jacob Lewis, 1439

ADDRESS: E Balto St

Spec.—1-10-21—M&T—1500 Rks.

E 59403

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59403

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 McElderry ST., WARD)

2-FULL NAME Samuel Russell

(a) RESIDENCE NO. 1613 McElderry ST., WARD 7-9

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

6 If married, widowed, or divorced HUSBAND of Clara Russell

DATE OF BIRTH (month, day, and year) 1882

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Skilled Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O&D

(c) Name of employer U.S. Post Office

BIRTHPLACE (city or town) D.C.
(State or country)

10 NAME OF FATHER Robt. Russell

11 BIRTHPLACE OF FATHER (city or town) D.C.
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) D.C.
(State or country)

Informant Clara Russell (wife)

(Address) 1613 McElderry St

Filed AUG 1 - 1930 19 Register

HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1930, to July 31, 1930,

that I last saw him alive on July 31, 1930,

and that death occurred, on the date stated above, at 7.45 p.m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Hypertensional arteriosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R Lidsky, M. D.

8/1 [illegible] (Address) 1924 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 8/3/30

20 UNDERTAKER Robert W. Williams — ADDRESS 1515 Mattison Ave

c.—1-30—M. & T.—250 Bks.

235970
E 59404

HEALTH DEPARTMENT—CITY OF BALTIMORE E 59404

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ST., WARD)

2-FULL NAME Henry Foulkes

(a) RESIDENCE NO. Johns Hopkins Hosp ST., 7-9 WARD
(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

f married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) Unknown

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

CCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer John Hopkins Hosp.

IRTHPLACE (city or town)
(State or country) England

0 NAME OF FATHER Charles

1 BIRTHPLACE OF FATHER (city or town) England
(State or country)

2 MAIDEN NAME OF MOTHER Unknown

3 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

Filed ..... 19 .....

C. HAMPSON JONES, M. D.
Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-1-1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 13, 1930, to Aug 1, 1930, that I last saw him alive on Aug 1, 1930, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:
Myocardial failure
Arteriosclerotic heart disease
(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) several years

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ludwig Kreuig, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Aug 4 1930

20 UNDERTAKER Lloyd W Little — ADDRESS 1125 Eutaw

c.—1-30—M. & T.—250 Bks.

E 59405 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59405

CERTIFICATE OF DEATH. 74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 1939 W. Franklin St WARD)

2-FULL NAME Emma Jane Senft

(a) RESIDENCE NO. 1939 W. Franklin ST., 20-27 WARD

(Usual place of abode)

(If non-resident give city or town and State)

ength of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widowed

married, widowed, or divorced HUSBAND of (or) WIFE of

ATE OF BIRTH (month, day, and year) Oct. 7-185

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79.	7	24	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Maryland

0 NAME OF FATHER Samuel M. Bell

1 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

2 MAIDEN NAME OF MOTHER Elizabeth Dufour

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant H. G. Wilkinson

(Address) 1939 W. Franklin St.

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31-1930

17 I HEREBY CERTIFY, That I attended deceased from July 15th, 1930 to July 31st, 1930

that I last saw her alive on July 30th, 1930

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 2 yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Senile Decay

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin H. Colegrove, M. D.

, 19 (Address) 530 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leuden Park Cemetery

DATE OF BURIAL Aug 2. 1930

20 UNDERTAKER Josiah Syfer

ADDRESS Reg W. North Ave

c.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59406 | CERTIFICATE OF DEATH | 90 E 59406

REGISTERED NO.

1—PLACE OF DEATH

TY OF BALTIMORE: (No. 1604 Clifton Ave. ST., WARD) 15-59

2—FULL NAME Louis Bridle

(a) RESIDENCE NO. 1604 Clifton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 73 yrs. 11 mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

~~married~~ widowed, or ~~divorced~~

HUSBAND of (or) ~~WIFE of~~ Emma Bridel

TE OF BIRTH (month, day, and year) Aug 26-1856

E Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
73	11	5	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work Teamster

) General nature of industry, siness, or establishment in hich employed (or employer) Retired 23

) Name of employer

RTHPLACE (city or town) Baltimore
tate or country) Maryland

NAME OF FATHER Don't Know

BIRTHPLACE OF FATHER (city or town)
(State or country) France

MAIDEN NAME OF MOTHER Don't Know

BIRTHPLACE OF MOTHER (~~city or town~~)
(State or country) Italy

Informant Mrs. Edward Dorer

(Address) 1604 Clifton Ave.

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31-1930

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1930, to July 31, 1930, that I last saw h~~im~~live on July 30, 1930 and that death occurred, on the date stated above, at 3:20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Jane Brown, M. D.

7/31. 1930 (Address) 1663 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 4 1930
20 UNDERTAKER	ADDRESS
Sarah Snyder	1600 W North Ave

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59407

CERTIFICATE OF DEATH

57 E 59407

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balt City Hosp St., 16-22 Ward)

2-FULL NAME Isaac Durant

(a) RESIDENCE NO. 1017 N Mount St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Mal	Col	unknown

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38?			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 0 8 9
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address) C. HAMPSON JONES, M. D.

15 1930 By ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetis
Mellitus

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) James M Hamilton, M. D.

(Address) 708 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL AUG 1 - 1930 19

20 UNDERTAKER

ADDRESS

THE MORGUE.

c.—1-30—M. & T.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59408

E 59408

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. Little Sisters of the Poor ST., 10-16 WARD)

2-FULL NAME Margaret A. Lauer

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) (State or country) England

0 NAME OF FATHER Thomas Hopkins

1 BIRTHPLACE OF FATHER (city or town) (State or country)

2 MAIDEN NAME OF MOTHER Mary Farrell

3 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Little Sisters of the Poor

(Address) Preston & Valley Av

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31st 1930

17 I HEREBY CERTIFY, That I attended deceased from July 24 1930, to July 31 1930,

that I last saw her alive on July 31 1930,

and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

Senility

Contributory (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard Wess M. D.

Aug 1 1930 (Address) 1216 N Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Aug 2 1930

ADDRESS Ave

20 UNDERTAKER Rita Medefield 914 Fremont

1-30—M. & T.—250 Blks

E 59409

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59409

CERTIFICATE OF DEATH.

71-001

REGISTERED NO. 9-47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., WARD

2-FULL NAME Mary Wolschlager

(a) RESIDENCE NO. 645 Gutman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced (of) HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July 1 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ---

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Myrtle Mette.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Hospital Records.

(Address)

Filed 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31-30

17 I HEREBY CERTIFY, That I attended deceased from 7-25, 1930, to 7-31, 1930,

that I last saw her alive on 7-31, 1930,

and that death occurred, on the date stated above, at 6 15 P. m.

The CAUSE OF DEATH* was as follows:

Subphrenic cellulitis chest

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Meningitis over

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7-26-30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) J Leyko, M. D.

7/30 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 8/2/1930

UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

30—M. & T.—100 B—50L

E 59410

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001
E 59410

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hosp (ST.) 9 (WARD) 17

2-FULL NAME Wm H. Putnam

(a) RESIDENCE NO. 500 Chesnut Hill Ave (ST.) WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Elyabeth

DATE OF BIRTH (month, day, and year) Oct 30-1851

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	9	11	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER John Putnam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Pohlman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Hosp Record.

(Address)

Filed 1930 192 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

10 Months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 31

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Smith, M. D. Coroner

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 8/4 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

c.—1-30—M. & T.—250 Blks.

E 59411
239370
Med.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59411

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

TY OF BALTIMORE: (No. ST., N. E. WARD)

2-FULL NAME Herbert Lynn

(a) RESIDENCE No. 39 S. East Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

f married, widowed, or divorced HUSBAND of or) WIFE of —

ATE OF BIRTH (month, day, and year) unknown

GE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
	14			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

IRTHPLACE (city or town) (State or country) Va.

0 NAME OF FATHER Charles

1 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

2 MAIDEN NAME OF MOTHER Elma ?

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant (Address) JOHNS HOPKINS HOSPITAL

Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-1-30

17 I HEREBY CERTIFY, That I attended deceased from 7-29-, 1930, to 8-1-, 1930, that I last saw h[illegible] alive on 8-1-, 1930, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Chronic rheumatic endocarditis

(duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary) Adhesive pericarditis

(duration) ✓ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Ludwig Kuenig, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 8/4/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

c.—2-29-28—L. F. S.—500 Bks.

E 59412

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59412

CERTIFICATE OF DEATH

REGISTERED NO. 1129

1—PLACE OF DEATH Franklin Square Hospital

TY OF BALTIMORE: (No. Fayette & Calhoun ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. William Goldsborough

(a) RESIDENCE NO. 1512 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Anna Goldsborough

TE OF BIRTH (month, day, and year) May 26th 1878

E Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
52	2	5	

CUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Warehouse

(c) Name of employer State of Md.

RTHPLACE (city or town) (State or country) St Marys Co Md

NAME OF FATHER Unknown

BIRTHPLACE OF FATHER (city or town) (State or country)

MAIDEN NAME OF MOTHER Unknown

BIRTHPLACE OF MOTHER (city or town) St Marys Co Md (State or country)

Informant Barbara V. Klassmeier

(Address) 714 W. Cross st

Filed 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31-30

17 I HEREBY CERTIFY, That I attended deceased from 7-26, 1930, to 7-31, 1930, that I last saw him alive on 7-31, 1930 and that death occurred, on the date stated above, at 3:45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic Diffuse Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) M. B. Schreiber, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 8/4/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59413 E 59413

CERTIFICATE OF DEATH

90

REGISTERED NO. 56

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2906 Kate ST., (WARD) 15

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmira Fitzgerald

(a) RESIDENCE NO. 2906 Kate ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank

7 DATE OF BIRTH (month, day, and year): Dec 18-1865

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	13 14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: Wm Seymour

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Mary Brandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

Informant: Elsie Fenn

(Address): 2906 Kate Ave

Filed 1930 Reg. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): August 1 at 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (inquest, autopsy or inquiry) thereon and from the evidence obtained by said (inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Regular

(Signed) M. Faik, M. D. Coroner

Aug 1 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: 8/4/1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

30—M. & T.—100 B—50L.

E 59414

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 59414

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1513 E North Ave ST., 8-17 (WARD)

2-FULL NAME Henry Vorsatz

(a) RESIDENCE No. Bay Shore Long Island NY ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 65 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

If married, widowed or divorced HUSBAND of (or) WIFE of Catherine Vorstag

DATE OF BIRTH (month, day, and year) Nov 23 1847

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	8	8	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) New York

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

Informant Christina Boecher

(Address) 1513 East North Ave

Filed 1930 C. HAMPSON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sarcoma R. Eye.

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Cy Lausten

(duration) ..... yrs. ..... mos. 1 day

18 Where was disease contracted if not at place of death? Long Island

Did an operation precede death? — Date of —

Was there an autopsy? Inquiry — What tests confirmed diagnosis? Autopsy Coron

(Signed) J. G. Blades, M. D. Coroner

, 19 (Address) 43 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bay Shore, Long Island

DATE OF BURIAL 8/2 1930

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul

Spec.—1-10-21 M&T 1500 Blks.

E 59415

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59415

CERTIFICATE OF DEATH.

90 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 612 S. Oldham ST., 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Wirtz

(a) RESIDENCE NO. 612 S. Oldham ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Kruppski

DATE OF BIRTH (month, day, and year) April 10, 1874

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56	3	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Joseph Kruppski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. William Stumke

(Address) 612 Oldham St.

1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1930

17

I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to Aug 1, 1930.

that I last saw her alive on July 31, 1930,

and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal disease

(duration) yrs. 6 mos 1 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Geo Keller M. D.

8-1-, 1930 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL Aug 4, 1930

20 UNDERTAKER John A. Moan

ADDRESS 1100 E. Balto St.

c.—1-30—M. & T.—250 Blks.

E 59416 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59416

CERTIFICATE OF DEATH. X 118-002

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. Church Home and Infirmary 5-8 WARD)

2-FULL NAME Mrs. Florence Ryan Colored

(a) RESIDENCE NO. Lake and Hollins Avenues WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Mr. Samuel Ryan

ATE OF BIRTH (month, day, and year) July 23 - 1864

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	0	8	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Harford Co.

0 NAME OF FATHER Abram Hitchcock

1 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co

2 MAIDEN NAME OF MOTHER Rachel Robinson

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co

Informant Frank Ryan

(Address) Hollins & Lake Ave

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1, 1930

17

I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to August 1, 1930,

that I last saw her alive on August 1, 1930,

and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Oscar E Hubbard, M. D.

, 19 (Address) 709 Cornwall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Aug 4 30
20 UNDERTAKER	ADDRESS
Chas Marshall	2539 Fall Rd

c.—1-30—M. & T.—250 Blks

E 59417

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59417

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals 76-37 REGISTERED NO.

TY OF BALTIMORE: (NO. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Groninger

(a) RESIDENCE NO. City Hospitals ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced
HUSBAND of
or) WIFE of Unknown

ATE OF BIRTH (month, day, and year) Feb. 28, 1862

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	5	3.	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

IRTHPLACE (city or town) Balto.
(State or country) Md.

0 NAME OF FATHER Godfred Groninger

1 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

2 MAIDEN NAME OF MOTHER Verna Wissel

3 BIRTHPLACE OF MOTHER (city or town) Bermany
(State or country)

Informant Records of
(Address) Balto. City Hosp.

Filed ... 1930 ... 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31-30

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 31, 1930, that I last saw him alive on July 31, 1930, and that death occurred, on the date stated above, at 5:55 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic.

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. Arnold Jr. M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL 8/4/1930

UNDERTAKER John J. Cowie & Son. ADDRESS 901 Hollins St.

c.—1-30—M. & T.—250 Blks.

E 59418 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59418

CERTIFICATE OF DEATH.

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (NO. 1201 N. Eden ST. 10-13 WARD)

2-FULL NAME Lilly Cohen

(a) RESIDENCE NO. 1201 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Herman Cohen

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
4	64			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

IRTHPLACE (city or town) (State or country) Poland

0 NAME OF FATHER Isaac Yellin

1 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

2 MAIDEN NAME OF MOTHER Hymes

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant L. Levin

(Address) 1139 E. Baltimore St.

C. HAMPSON JONES, M. D.

Filed 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1-1930

17

I HEREBY CERTIFY, That I attended deceased from Feb. 19 29 to Aug 1 19 30,

that I last saw h[illegible] alive on Aug 1 19 30,

and that death occurred, on the date stated above, at 1.30 P. m. S.T.

The CAUSE OF DEATH* was as follows:

Carcinoma of the gall bladder

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab.

(Signed) Sidor L. Levy, M. D.

Aug. 1930 (Address) 1332 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Lebanon

UNDERTAKER Jos Levine, 1139

DATE OF BURIAL 8-3- 1930

ADDRESS E. Baltimore St.

...—1-30—M. & T.—350 Bks.

E 59419

39340

E 59419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 37-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO. ..... ST., 4-13 WARD)

2-FULL NAME Herbert Hoover Johnson

(a) RESIDENCE NO. 1813 E Eager St- ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	Infant-

If married, widowed, or divorced HUSBAND of (or) WIFE of

ATE OF BIRTH (month, day, and year) Feb 12 1929

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	18	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Herbert Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hollinse Graves

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Reads

(Address) JOHNS HOPKINS HOSPITAL

Filed ..... 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31-1930

17

I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to July 31, 1930,

that I last saw him alive on July 31, 1930,

and that death occurred, on the date stated above, at 11 40 a. m.

The CAUSE OF DEATH* was as follows:

miliary tuberculosis

tuberculous meningitis

(duration) ..... yrs. ..... mos 30 da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? X-ray

(Signed) R. O'Z. Wrenn, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Memorial Pk

DATE OF BURIAL Augy 1930

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1715 Eastlake Ave

c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

59420 194 E 59420

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 215 St Mathews ST., 5-8 WARD)

2—FULL NAME James Sample

(a) RESIDENCE NO. 1213 St Mathews ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occ[illegible] mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: Female, Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

married, widowed, or divorced, BUSBAND of (or) WIFE of: Wilbert Sample

TE OF BIRTH (month, day, and year): 1884

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

CUPATION OF DECEASED

) Trade, profession or rticular kind of work: Domestic

) General nature of industry, siness, or establishment in hich employed (or employer): Private

) Name of employer

THPLACE (city or town) (tate or country): Md

NAME OF FATHER: Sidney Mercer

BIRTHPLACE OF FATHER (city or town) (State or country): Md

MAIDEN NAME OF MOTHER: Sallie Hemdon

BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Wilbert Sample

(Address) 1213 St Mathews

C. HAMPSON JONES, M. D.

Filed 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31 1930

I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to July 31, 1930.

that I last saw him alive on July 31, 1930.

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Heart Exhaustion (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D.

, 19 (Address) 508 Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MT Calvary cemetery

DATE OF BURIAL: Aug 2 1930

UNDERTAKER: Wm A Elliott

ADDRESS: 1725 Eden ave

c.—1-30—M. & T.—250 Blks.

59421 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 59421

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 15-68 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mabel Young

(a) RESIDENCE No. 3271 Brightwood Ave St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Cullis Moore Young

DATE OF BIRTH (month, day, and year) Nov. 17 1883

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	8	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Thos. Balderston

11 BIRTHPLACE OF FATHER (city or town) Local Co (State or country) Md

12 MAIDEN NAME OF MOTHER Clara V. Ashton

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

Informant Cullis M. Young

(Address) 3271 Brightwood Ave

Filed ..... C. HAMPSON JONES, M. D. Registrar

1930 No. 1111

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to Aug. 1, 1930, that I last saw her alive on Aug 1, 1930, and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Retroperitoneal Lymph Nodes

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Erosion of Bloodvessels & secondary hemorrhage (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Yes Date of July 31 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George H. Yeager M. D.

8/1, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL Aug 4, 1930

UNDERTAKER Wm Fickner Sons — ADDRESS Md Pa

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59422

CERTIFICATE OF DEATH

168 E 59422

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3104 Sequoia Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Leslie Beckner

(a) RESIDENCE NO. 3104 Sequoia Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Maude Esther Beckner

DATE OF BIRTH (month, day, and year) July 17, 1883

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	—	13	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Naval Officer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

086

BIRTHPLACE (city or town) (State or country) Union, West Virginia

10 NAME OF FATHER Spurgeon M. Beckner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Union, West Virginia

12 MAIDEN NAME OF MOTHER Mary Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Union, West Virginia

Informant Mrs. Harry L. Beckner

(Address) 3104 Sequoia Ave

Filed C. HAMPSON JONES, M. D. 192 Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 19 30

17 I HEREBY CERTIFY That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Hanging Sudden

(duration) yrs.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inquest

(Signed) H. Hampson Jones, M. D. Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Park Memorial DATE OF BURIAL Aug. 2, 19 30

20 UNDERTAKER Wm. J. Tuckwell ADDRESS Mt Royal Ave

c.—1-30—M. & T.—250 Blks.

E 59423 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59423

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH (a) CITY OF BALTIMORE: (No.) University Hospital ST. 10-1 WARD)

2-FULL NAME Alice W. Smith.

(a) RESIDENCE NO. 1021 Valley St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced (or) HUSBAND of WIFE of Henry Smith

DATE OF BIRTH (month, day, and year) July 29 1868

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62		3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER Charles Page

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Nat Knowles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant Wm. Carl W. Smith (Son)

(Address) 1021 Valley St.

FILED 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to Aug 1st, 1930, that I last saw her alive on Aug 1st, 1930, and that death occurred, on the date stated above, at 1:07 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Arteriosclerosis with

Hypertension.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Laboratory findings with autopsy

(Signed) George N. Yeager, M. D.

8/1, 1930 (Address) U. University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Aug 4, 1930

20 UNDERTAKER Elmer W. Conklin

ADDRESS 912 E. Eager St.

C.—1-30—M. & T.—250 Bks.

E 59424

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59424

CERTIFICATE OF DEATH.

44

8:45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2825 Lake Ave ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George D. Bruchey.

(a) RESIDENCE No. 2825 Lake ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 8 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Bruchey

7 DATE OF BIRTH (month, day, and year) Nov 26-1882

AGE: Years 47 Months 8 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Rubber Pencil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Wm Bruchey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ada Lehman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Minnie Bruchey

(Address) 2825 Lake Ave

Filed 1930

C. HAMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1-30

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1928 to July 1, 1930

that I last saw h. alive on July 20, 1930

and that death occurred, on the date stated above, at 8:45 P.M. a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 2 yrs. ? mos ds.

CONTRIBUTORY (Secondary) Cancer Cachexia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of apr-1929

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) H. A. Sigurt, M. D.

, 19 (Address) Medical arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: aug. 4 1930

20 UNDERTAKER: John Ulrich

ADDRESS: 2 E Preston

E 59425

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59425

CERTIFICATE OF DEATH.

159-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 S. Robinson ST., 1-W WARD)

2-FULL NAME Anna L. Youngbar

(a) RESIDENCE NO. 815 S. Robinson ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) July 23rd 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto. Md.
(State or country)

10 NAME OF FATHER Frank Youngbar

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary Baier

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

Informant Frank Youngbar Father
(Address) 815 S. Robinson St.

Filed 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1930, to Aug 2, 1930, that I last saw her alive on Aug 2, 1930, and that death occurred, on the date stated above, at 1.40 a. m.

The CAUSE OF DEATH* was as follows:

Open Foramen Ovale

(duration) ....yrs. ....mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Titlow, M. D.

8/2, 1930 (Address) 315 S. Highland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL Aug 2nd 1930

20 UNDERTAKER Lilly + Zeller Inc

ADDRESS 403 S. Wolfe St

c.—1-30—M. & T.—250 Blks.

E 59426 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 59426

1-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Drivin Hosp

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ..... ST., 1-13 WARD X

2-FULL NAME Velma Dappington

(a) RESIDENCE NO. Mein Ave & Hammons Rd ST., Brooklyn Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	We	Married

If married, widowed, or divorced HUSBAND of or) WIFE of

ATE OF BIRTH (month, day, and year) Unknown 1900

GE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
30.			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work A Wash 37 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Unknown

10 NAME OF FATHER Thomas Harmon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Hyman Magruning
(Address) Severn Md

Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to Aug 1, 1930, that I last saw h alive on Aug 1, 1930 and that death occurred, on the date stated above, at 10:45 P. m. EST

The CAUSE OF DEATH* was as follows:

~~Typhoid Fever~~
Paratyphoid Fever Type A WBK 8-6-30

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Brooklyn Md ?
No

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Hector B. Black, M. D.

, 19 (Address) Drivin Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md	Aug 4. 1930
UNDERTAKER Edward H. Fisher	ADDRESS Laurel

Edwin H. Griffith

—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59427 — 129 E 59427

REGISTERED NO.

1—PLACE OF DEATH Maryland General Hosp.

TY OF BALTIMORE: (No. 1200 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edwin H. Griffith

(a) RESIDENCE NO. 302 E. 21st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred ? yrs. ? mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

married, widowed, or divorced HUSBAND of → Mrs. E.H. Griffith
(or) WIFE of

TE OF BIRTH (month, day, and year) Mar. 14, 1868

E Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	4	17	

CUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 029

(b) General nature of industry, business, or establishment in which employed (or employer) Electrical

(c) Name of employer —

RTHPLACE (city or town) Baltimore
State or country) County

0 NAME OF FATHER Samuel K. Griffith

1 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) County

2 MAIDEN NAME OF MOTHER Katherine Schutt

3 BIRTHPLACE OF MOTHER (city or town)
(State or country) Penn.

Informant Hospital Records

(Address)

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1930, to Aug 1, 1930, that I last saw h... alive on Aug 1, 1930, and that death occurred, on the date stated above, at 8 40 H. m. (St...)

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Meningitis
Myocardial Insufficiency
5 weeks (history)
(probable onset July 1)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis Chronic Nephritis
? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms. Examination.

(Signed) Robert V. Ennis, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Aug 4 1930

UNDERTAKER E. Thunow & Son — ADDRESS 3615 Eastern Ave.

...c.—1-30—M. & T.—250 Blks.

E 59428 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 59428

31

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 912 N. Bond ST., 1-13 (WARD)

2-FULL NAME Samuel Mitchell

(a) RESIDENCE NO. 912 N. Bond ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Elizabeth Mitchell

DATE OF BIRTH (month, day, and year) about 1885

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

BIRTHPLACE (city or town) Balto. Md.
(State or country)

10 NAME OF FATHER Mathew Mitchell

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Jolena Henson

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

Informant Elizabeth Mitchell
(Address) 912 N. Bond St.

AUG 2 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1930, to July 30, 1930, that I last saw h.~~im~~ alive on July 30, 1930, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos 16 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Acid Fast

(Signed) C. B. LeCompte, M. D.

, 19 (Address) 1113 ½ Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon — DATE OF BURIAL Aug 2 1930

UNDERTAKER Mrs. R. A. Elliott — ADDRESS 1725 Eastlandave

c.—1-30—M. & T.—250 Bks.

✓ E 59429

E 59429

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 22-63 33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 3801 Grantley Road ST., WARD)

2-FULL NAME Margaret Bell Gill

(a) RESIDENCE NO. 3801 Grantley Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
Husband of
or) WIFE of James D Gill

ATE OF BIRTH (month, day, and year) Sept 2-1877

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	10	29	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hswf. 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

IRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Wm E Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E Nalls

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant James D Gill

(Address) 3801 Grantley Rd

C. HAMILTON JONES, M. D.

Registrar

Fil 1930 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 - 1930

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to Aug. 1, 1930, that I last saw her alive on July 31, 1930, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) chronic Tuberculous Peritonitis Pernicious anemia (duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? Clinical findings

(Signed) Maurice E. Shanbar M. D.

8/2, 1930 (Address) 3300 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Grove Md — DATE OF BURIAL 8/4 1930

20 UNDERTAKER Edw L Tipton Hampstead Md — ADDRESS

Spec.—1-10-21—M&T—1500 Bke.

E 59-130 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59-130

CERTIFICATE OF DEATH. 159-003

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 Chapel St ST. 4-10 WARD)

2-FULL NAME Baby Rose Lavazza

(a) RESIDENCE NO. 2223 Chapel St WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug 1, 1930

7 AGE — Years: — Months: — Days: 1 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Lavazza

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Italy

12 MAIDEN NAME OF MOTHER Agatha Kowalski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Agatha Kowalski
(Address) 2223 Chapel St.

Filed Aug 2 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2 1930

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1930, to August 1, 1930, that I last saw h[illegible] alive on August 1, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Spina-Bifida

(duration) yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Joseph L. Valentine M. D.

Aug 2 1930 (Address) 1K So Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL aug 2nd 1930

20 UNDERTAKER Frank V. Ripetone — ADDRESS 241 E. Balto St

r.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

59431 E 59431

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 3701 Yosemite Ave. ST. WARD)

2—FULL NAME Norman H. Tagg.

(a) RESIDENCE NO. 3701 Yosemite Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred ✓ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X | 4 COLOR OR RACE | 5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)

ale | White | married

married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Eva C. Tagg.

ATE OF BIRTH (month, day, and year) June 7 1845

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
35.			

CCUPATION OF DECEASED

a) Trade, profession or particular kind of work Pharmacist

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

RTHPLACE (city or town) Littlestown Pa.
State or country)

0 NAME OF FATHER Milton H. Tagg.

1 BIRTHPLACE OF FATHER (city or town) Carroll Co.
(State or country) Md.

2 MAIDEN NAME OF MOTHER Margaret Selby

3 BIRTHPLACE OF MOTHER (city or town) Carroll Co.
(State or country) Md.

Informant Eva C. Tagg.
(Address) 3701 Yosemite Ave.

Filed 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/1/1930

17

I HEREBY CERTIFY, That I attended deceased from February 23, 1930, to Aug 1, 1930,

that I last saw h— alive on July 30, 1930

and that death occurred, on the date stated above, at about 3 ~~A~~ P. m. D.S.T.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial disease.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) [illegible], M. D.

Aug. 1930 (Address) 342 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn and Elmira N.Y.

DATE OF BURIAL 8/4/1930

20 UNDERTAKER Horace F Burgee 363

ADDRESS Fulton Road

c.—1-30—M. & T.—250 Blks.

59432

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59432

CERTIFICATE OF DEATH.

74-001

27-53

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) 104 Edgevale Road ST. WARD)

2-FULL NAME Mary Adreon Husted

(a) RESIDENCE NO. 104 Edgevale Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
ngth of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Husted

6 DATE OF BIRTH (month, day, and year) Sept. 29, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pocomoke City
(State or country) Md.

10 NAME OF FATHER Dr. Joseph Adreon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Winifred Cooper

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

Informant Mrs. R. Brooke Maxwell
(Address) 104 Edgevale Road

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 - 1930

17 I HEREBY CERTIFY That I attended deceased from July 22, 1930, to July 31, 1930, that I last saw h alive on July 31 - 1930, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Left Hemiplegia

(duration) ....yrs. ....mos ....da.

CONTRIBUTORY (Secondary) Essential Hypertension
(duration) 2 yrs ....mos. ....da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? —

(Signed) H. Gibson Foster, M. D.

7/1, 1930 (Address) 4822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Aug. 2, 1930

20 UNDERTAKER John O. Mitchell & Sons, 1900 Eutaw Pl.

ADDRESS

John O. Mitchell & Sons

...—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59433 | 162 | E 59433

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 9209 Madeira ST., 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Pete

(a) RESIDENCE NO. 920 N Madeira ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

If married, widowed, or divorced HUSBAND of (or) WIFE of —

ATE OF BIRTH (month, day, and year) Aug 2/30

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

IRTHPLACE (city or town) Balto.
(State or country)

10 NAME OF FATHER Thos Pete

11 BIRTHPLACE OF FATHER (city or town) Balt.
(State or country)

12 MAIDEN NAME OF MOTHER Eliz. Hirt

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country)

Informant Thos Pete

(Address) 920 N Madeira St

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1930, to Aug 2, 1930, that I last saw h[illegible]live on Aug 2, 1930 and that death occurred, on the date stated above, at 12.20 P.M.

The CAUSE OF DEATH* was as follows:

Acute Toxemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Rymer M. D.

Aug 2 1930 (Address) 901 N Edwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 2 1930
20 UNDERTAKER	ADDRESS
Grant Brock & Son 1906	Eden

Spec.—12-9-25—A Co.—200 Bks.

E 59434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 59434

1-PLACE OF DEATH

City of BALTIMORE: (No. 110 S. Fagley St., 26-37 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucia De Leo

(a) RESIDENCE NO. 110 S. Fagley St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Single

3a If married, widowed, or divorced WIFE of (or) HUSBAND of

6 DATE OF BIRTH (month, day, and year): April 21 – 1912

7 AGE: Years 18 | Months 3 | Days 10 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Morgantown

(State or country) W. Va.

PARENTS

10 NAME OF FATHER Nicola De Leo

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Italy

12 MAIDEN NAME OF MOTHER Di Pietrantonio

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Phila. Pa.

14 Informant Nicola De Leo

(Address) 110 S. Fagley

15 Filed _____, 19____ C. HAMPSON JONES, M. D. Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug. 1 / 30

17

I HEREBY CERTIFY, That I attended deceased from May 16 1930, to Aug 1, 1930, that I last saw h[illegible] alive on Aug 1, 1930, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) —

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted —

If not at place of death_____

Did an operation precede death? No Date of_____

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Philip Artigiani M. D.

, 19 (Address) 2940 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak. Lawn. Cem. — Date of Burial: 8-4 1930

20 UNDERTAKER: Wendell J. Keppel — ADDRESS: 300 S. Eden St

Cor.—10-10-29—A Co.—100 Bks.

E 59435

HEALTH DEPARTMENT—CITY OF BALTIMORE

166 E 59435

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Univ Hospital St., Ward) 19.50

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Virginia Beefeld

(a) RESIDENCE NO. 2205 Wilfong ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Walter

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER P. D. Mullen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Cora Clapsaddle

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Walter Beefeld
(Address) 2205 Wilfong ave

Filed 8-2-1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death
on the day stated above.
The CAUSE OF DEATH was as follows:
Backbone Paralysis
Suicide
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Mosmiller, M. D.
8-2, 1930 (Address) 2632 Reisterstown

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel cem

DATE OF BURIAL Aug 2 1930

UNDERTAKER Wendell J Dippel

ADDRESS 300 S Edm st

...c.—1-30—M. & T.—250 Blks.

E 59436 ✓ E 59436

59436 HEALTH DEPARTMENT—CITY OF BALTIMORE

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3705 Eggerton Road ST., 27-63 WARD)

2-FULL NAME Sarah Levin

(a) RESIDENCE NO. 3705 Eggerton Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Levin

DATE OF BIRTH (month, day, and year) 1873

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto., Md.

10 NAME OF FATHER Jacob Goldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sashard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Levin

(Address) 1739 Eutaw Pl.

Filed 8-3-1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1-1930

17 I HEREBY CERTIFY, That I attended deceased from 9/10, 1930, to 8/1, 1930, that I last saw her alive on 8/1, 1930, and that death occurred, on the date stated above, at 2 A.M. S.T.

The CAUSE OF DEATH* was as follows:

Carcinoma — (General metastases) — Primary probably Pancreas

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Johns Hopkins Hospital

(Signed) Wm. Brumbaugh, M. D.

8/2, 1930 (Address) 22 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon

DATE OF BURIAL 8-3-1930

20 UNDERTAKER Joel Levin

ADDRESS 1739 E. Balto. St.

c.—1-30—M. & T.—250 Blks.

239315
E 59437

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 59437

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (NO. ..... ST., 19 WARD)

2-FULL NAME Sarah Elizabeth Burrell

(a) RESIDENCE NO. 1511 E Monument ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

If married, widowed, or divorced (or) HUSBAND of / WIFE of: George

DATE OF BIRTH (month, day, and year): Dec-3-1889

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	7	29 28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Hl

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Del

10 NAME OF FATHER: Frank Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Lana Dueen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Del

Informant JOHNS HOPKINS HOSPITAL (Address)

Filed 1930. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug-1-1930

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to Aug 1, 1930, that I last saw her alive on Aug 1, 1930, and that death occurred, on the date stated above, at 130 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure. following operation for Myomata uteri and Adeno carcinoma of body of uterus

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Myomata uteri Adeno carcinoma of uterus

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of July 28, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. S. Everett, M. D.

8/1, 1930 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harrington Del — DATE OF BURIAL: aug 3 1930

20 UNDERTAKER: Edward Bergen — ADDRESS 1681 orleans st

c.—1-30—M. & T.—250 Blks.

89 742
E 59438

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

126 E 59438

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

TY OF BALTIMORE: (No. ST., 6-10 WARD)

2-FULL NAME James Brooks

(a) RESIDENCE NO. 102 N. Durham ST., ST WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Black	married

If married, widowed, or divorced HUSBAND of (or) WIFE of

ATE OF BIRTH (month, day, and year) unknown

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) md

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

Informant Records

(Address) JOHNS HOPKINS

Filed 3 - 1930 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2-30

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1930, to Aug 2, 1930, that I last saw him alive on Aug 2, 1930, and that death occurred, on the date stated above, at 9 40 a-m.

The CAUSE OF DEATH* was as follows:

Perforation of sigmoid with generalized peritonitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Diarrhea of unknown origin ? (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of 7-31-30

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy finding

(Signed) S A Campbell M.D., M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parsbury cemetery

DATE OF BURIAL aug 6 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 orleans st

c.—1-30—M. & T.—250 Blks

E 59439 **HEALTH DEPARTMENT—CITY OF BALTIMORE** X 38 E 59439

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.) ST., 11-24 (WARD)

2-FULL NAME William Tyler

(a) RESIDENCE NO. 437 W. Biddle ST., WARD S. C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Maud Tyler

ATE OF BIRTH (month, day, and year) April ?1897

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
33	~~40~~	3		

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer Cambridge Iron & Metal

IRTHPLACE (city or town) (State or country) S. C.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records of

(Address) Balto. City Hosp.

Filed 1930. 19 C. H[illegible]SON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31-30

17 I HEREBY CERTIFY, That I attended deceased from 7-28-30, 19..., to 7-31-30, 19...,

that I last saw him alive on 7-31-30, 19...,

and that death occurred, on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

DATE OF BURIAL aug 4 1930

UNDERTAKER Edmond Bryan

ADDRESS 1631 orleans st

e.—2-29-28—L. F. S.—500 Bks.

Annie Sticker

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59440 — 129 — E 59440

REGISTERED NO.

1—PLACE OF DEATH

TY OF BALTIMORE: (No. 139 W. Randell ST., 23-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Sticker.

(a) RESIDENCE NO. 139 W. Randall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 71 yrs. 11 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

married, widowed, or divorced HUSBAND of (or) WIFE of John Sticker.

6 DATE OF BIRTH (month, day, and year) Aug. 12, 1858.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71,	11,	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

10 NAME OF FATHER Michael Grife.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

Informant Charles E. Foss.

(Address) 139 W. Randall.

Filed AUG 6 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to Aug 1, 1930.

that I last saw HER alive on Aug 1, 1930

and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) R. H. Campbell, M. D.

8/2, 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudan Hill Cem	Aug 4 1930
20 UNDERTAKER	ADDRESS
C. Edward Evans	88 E Fayette

c.—2-29-28—L. F. S.—500 Bks.

E 59441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88 E 59441

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No.) 1516 W. Saratoga ST. 18 WARD

2—FULL NAME Mabel Colthorn Perry

(a) RESIDENCE NO. 1516 W. Saratoga ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter Perry

ATE OF BIRTH (month, day, and year): 1894

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 0 31

(c) Name of employer

RTHPLACE (city or town) State or country): Balto

0 NAME OF FATHER: Wm Colthorn

1 BIRTHPLACE OF FATHER (city or town) (State or country): Va

2 MAIDEN NAME OF MOTHER: Carter Russell

3 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

Informant: Bessie Clark

(Address): 1015 Round Hill

Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31/30

17 I HEREBY CERTIFY, That I attended deceased from July 11, 19 30, to July 31, 19 30

that I last saw h alive on July 31, 19 30

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Jones M. D.

8/1, 19 30 (Address) 1516 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion

DATE OF BURIAL: Aug 3 1930

UNDERTAKER: John H. Toadvine

ADDRESS 1027 Round Hill

Spec—12-23-21—E.B.R.S.—400 Bks.

0094

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

71-001

E 59442

E 59442

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1526 N. Stricker St. 14-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbert Morris

(a) Residence No. 1526 N. Stricker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Male

4-COLOR OR RACE Colored

5-Single, Married, Widowed, or Divorced (Write the word.) Single

6-If married, widowed, or divorced HUSBAND of (or) WIFE of —

7-DATE OF BIRTH (month, day and year) April 18 1928

8-AGE. 2 yrs. 3 mos. 1918 ds. If LESS than 1 day, ...hrs. or....min.

9-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10-BIRTHPLACE (City or Town) (State or Country), Balto Md

PARENTS

10-NAME OF FATHER Earl Morris

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary Strung

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

11- (Informant) Earl Morris

(Address) 1526 N. Stricker St

13- 3 - 1930 C. HAMPTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH (month, day and year) Aug 1st 30

17- I HEREBY CERTIFY, That I attended deceased from July 28 1930 to Aug 1st 1930.

That I last saw h.is alive on July 31st 1930.

and that death occurred, on the date stated above, at 8A m.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C M Lawrence M. D.

, 19 (Address) 1232 Madison Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn DATE OF BURIAL Aug 4 1930

20-UNDERTAKER Edmondson & Knowles ADDRESS 628 N Eutaw

...c.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2391/59443 Ped. 100-001 E 59443

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

...ITY OF BALTIMORE: (NO. ST., WARD

2-FULL NAME Howard Clay

(a) RESIDENCE NO. 575 Moore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

...EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
...male	black	—

If married, widowed, or divorced HUSBAND of (or) WIFE of —

...DATE OF BIRTH (month, day, and year) 10-27-27

...AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	2 2½	9	4	

...OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

...IRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Charles Clay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha Clare

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant (Address) Coroner JOHNS HOPKINS HOSPITAL

...Filed 1930 ... HAROLD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-1-30

17 I HEREBY CERTIFY, That I attended deceased from 7-21-, 1930, to 7-21-, 1930, that I last saw him alive on 8-1-, 1930, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

primary bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? X-ray

(Signed) H. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL Aug 4 1930

20 UNDERTAKER Carroll D Hawley

ADDRESS Baltimore

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59444

E 59444

CERTIFICATE OF DEATH X 45 16

5 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4014 Park Hts Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Amanda Elizabeth Spencer

(a) RESIDENCE NO. 4014 Park Hts Ave St. Ward Carroll Co Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. 3 mos. ✓ ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: James Hutchinson Spencer.

6 DATE OF BIRTH (month, day, and year): Sept 21 – 1859

7 AGE: Years 70 Months 10 Days 11

IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER John Lockard

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Carroll Co. Md

12 MAIDEN NAME OF MOTHER Mary Ogg.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Carroll Co Md

14 Informant (Address) Harry E Spencer 4014 Park Heights Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Aug 2 – 1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to Aug 2, 1930, that I last saw her alive on August 1, 1930, and that death occurred, on the date stated above, at 3.30a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) ✓ yrs. 1 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) George E Shannon, M. D.

8/2. 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Carroll Co Md Mt Pleasant Cem

Date of Burial: Aug 4 1930

UNDERTAKER: Wm J Tucker Sons

ADDRESS: Md Pa

File 3 – 1930 C. HAMPSON JONES, Registrar

Per

ec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59445

E 59445

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 2715 St. Paul ST. 17 WARD 19)

2-FULL NAME Adolph A. Meilefk

(a) RESIDENCE NO. 2715 St. Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Stella Meilefk

DATE OF BIRTH (month, day, and year) Sept 5 1857

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	10	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER August Meilefk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Munder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Walter Meilefk

(Address) 3218 St. Paul St.

Filed 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 - 1930

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1930, to Aug 1, 1930,

that I last saw him alive on Aug 1 1930

and that death occurred, on the date stated above, at 10 P.M. D.S.T.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(dutation) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypertension - Chr. neplritis

myocarditis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? P.E. & Lab.

(Signed) Elmer E. Todd, M. D.

Aug 2, 1930 (Address) 735 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Aug 4 1930

20 UNDERTAKER W. J. Tucker & Son

ADDRESS North + Penn Sts

80—M. & T.—100 B—50L

E 59446

HEALTH DEPARTMENT—CITY OF BALTIMORE

170 ✓

E 59446

CERTIFICATE OF DEATH

REGISTERED NO. 20-27

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square ST., WARD)

2-FULL NAME Jas. C. Hammett

(a) RESIDENCE NO 1833 Edmondson St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Dec 2 1883

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	8	—	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Tyllleton Hammett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jennie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant James M. Mangan

(Address) 1833 Edmondson Ave

C. HAMPSON JONES, M. D.

File 1930 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Pistol Shot Wound

Duration (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. A. Brooks, M. D. Coroner

Aug 2, 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Central Mt. Olivet Cemetery Prince Frederick Calvert Co. Md

20 UNDERTAKER George L. Smith

DATE OF BURIAL 8/4/30 19

ADDRESS 1532 Hollins

Cor.—10-10-29—A Co.—100 Bks.

E 59447

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59447

CERTIFICATE OF DEATH

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital St. 25 Ward)

2-FULL NAME Catherine Moore

(a) RESIDENCE NO. 921 E Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James B. Moore

6 DATE OF BIRTH (month, day, and year) July 2 1859

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	71	0	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer self

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Mrs Katie Campbell
(Address) 807 N Central Ave

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Probable (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 921 E Lombard

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Hunter M. D.

Aug 2 1930 (Address) 7006 Chestnut

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 8/4/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

- 1930

...ec.—1-30—M. & T.—250 Blks.

59448

HEALTH DEPARTMENT—CITY OF BALTIMORE

V

117 E 59448

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph Hospital — REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Edmondson ST., 68 WARD

2-FULL NAME Edwin Meredith

(a) RESIDENCE NO. 403 N Fulford ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced, (write the word)~~
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of _____

DATE OF BIRTH (month, day, and year) Jan 6 1927

AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	2	7	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Wm C Meredith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Church Hill Md

12 MAIDEN NAME OF MOTHER Mary Cart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Camden N J.

Informant Mrs C Meredith

(Address) 403 N Fulford ave

Filed 1930 S. HARRISON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-2-30

17 I HEREBY CERTIFY, That I attended deceased from 8-1-30, 19..., to 8-2-30, 19..., that I last saw h[illegible] alive on 8-2-30, 19..., and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Appendicitis
Peritonitis

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 8-1-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) I B Hendrix, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Aug 4 1930

20 UNDERTAKER Robt J Turner — ADDRESS 1 Broadway

...c.—1-30—M. & T.—250 Blks.

E 59449

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59449

CERTIFICATE OF DEATH.

X 161-002

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 11.3

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Wunder

(a) RESIDENCE NO. Fullerton Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 1 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX — male

4 COLOR OR RACE — White

5 Single, Married, Widowed, or Divorced, (write the word) — 10.2

If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) July 28 1930

AGE — Years — Months — Days 6 — If LESS than 1 day, ... hrs. or ... min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) Balto. (State or country) Maryland

10 NAME OF FATHER Harry Wunder

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Longnecker

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Maryland

Informant Harry Wunder

(Address) Fullerton Md

Filed 3 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7, 1930

I HEREBY CERTIFY, That I attended deceased from Aug 2nd, 1930 to Aug 3, 1930

that I last saw h[illegible] alive on Aug 3 1930

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage - following delivery.

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Foetus Viamatorum

(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death? At time of birth

Did an operation precede death? Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. G. Lynch, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Aug 4, 1930

20 UNDERTAKER Frederick Loudon Sons — ADDRESS [illegible]

ec.—1-30—M. & T.—250 Bks

E 59450 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓

CERTIFICATE OF DEATH 69 90 E 59450

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., WARD)

2-FULL NAME David Price

(a) RESIDENCE No. ~~107 Caroline~~ 1211 N. Bond St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie

DATE OF BIRTH (month, day, and year) 1873

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Abraham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ella Wolman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Hospital Records - Incomplete (Address)

Filed Aug 3 1930 C. HAYDOCK JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-1-30

17 I HEREBY CERTIFY, That I attended deceased from 2-29, 1930, to 8-1, 1930, that I last saw him alive on 8-1-, 1930, and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic cardiovascular disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 2 yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

8/30 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Herring Run	Aug 3 30
20 UNDERTAKER Jack Levine	ADDRESS 1X 39 E. Read St

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59451

CERTIFICATE OF DEATH

1/4-001 ✓ E 59451

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Church Home Inf. St., 7-9 Ward)

2-FULL NAME Alonzo G. Sweeten

(a) RESIDENCE NO. #636 N. Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Amas Etta Sweeten

6 DATE OF BIRTH (month, day, and year) Oct. 16th. 1854

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	75	9	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Tin Plate Co.
(c) Name of employer

9 BIRTHPLACE (city or town) ...
(State or country) Jessups Howard County

PARENTS

10 NAME OF FATHER Wm. C. Sweeten

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Phila Pa.

12 MAIDEN NAME OF MOTHER Mahalie A.

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Deerfield N.H.

14 Informant Amas E. Sweeten
(Address) 636 N. Broadway

15 Filed 3-1930 C. HAMPSON JONES, M. D. Registrar

By ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, Autopsy or Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(duration) ? yrs. ... mos. 4 hrs.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ... yrs. ... mos. 4 hrs.

18 Where was disease contracted? 636 N Broadway If not at place of death? ...

Did an operation precede death? — Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) A G Slade, M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govans Presbyterian Cem.	Aug 4 1930
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Eden

Spec.—1-30—M. & T.—250 Blks.

59452

HEALTH DEPARTMENT—CITY OF BALTIMORE E 59452

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 N Highland Av ST., 26-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Wolf

(a) RESIDENCE NO. 603 N. Highland Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Pauline Wolf

DATE OF BIRTH (month, day, and year) May 8/51

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	2	28	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Saloma —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

Informant Pauline Wolf

(Address) 603 N. Highland Av

Filed 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1/30

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to Aug 1, 1930, that I last saw him alive on Aug 1, 1930, and that death occurred, on the date stated above, at 3 55 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

Nephritis Chronic

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) E. H. Dorsey, M. D.

, 19 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Aug 4 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

Dec.—1-30—M. & T.—250 Blks.

23964 E 59453

HEALTH DEPARTMENT—CITY OF BALTIMORE

51 E 59453

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 1827 WARD

2-FULL NAME Emory E. Knode

(a) RESIDENCE NO. 5-35-N-Fulton ST., Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) May 1-1917

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
13	4	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Emory Knode

11 BIRTHPLACE OF FATHER (city or town) Md— Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Rose Brunner

13 BIRTHPLACE OF MOTHER (city or town) Md— Baltimore (State or country)

Informant Records— (Address) Johns Hopkins Hospital

Filed 1930 H. A. Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-2-30

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to Aug 2, 1930, that I last saw him alive on Aug 2, 1930, and that death occurred, on the date stated above, at 2 10 P. m.

The CAUSE OF DEATH* was as follows:

Erythema Toxicosum

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) rheumatic fever + chorea

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Emil B. Cekada, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cemetery

DATE OF BURIAL Aug 4 1930

UNDERTAKER J. B. Stephens

ADDRESS 1850 W Baltimore

...c.—1-30—M. & T.—250 Blks.

E 59454

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59454

CERTIFICATE OF DEATH.

REGISTERED NO. 20-69/123

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 20 WARD)

2-FULL NAME Fred W. Hedrick

(a) RESIDENCE NO. 48 Bowman Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

If married, widowed, or divorced HUSBAND of or) WIFE of Susie E Hedrick

DATE OF BIRTH (month, day, and year) Feb 14 1875

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
55	6	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamster

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md

10 NAME OF FATHER Fred Hedrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lettie Feick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Susie E. Hedrick

(Address) 48 Bowman Av

Filed ... 1930 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to Aug 7, 1930,

that I last saw him alive on Aug 7, 1930,

and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis with Cholelithiasis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Congestive heart failure

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 1 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Clin & Operative

(Signed) Henry J. Seward, M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Aug 8 1930

UNDERTAKER C. H. [illegible], M. D.

ADDRESS 1130 N. Patterson Park Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

59455

CERTIFICATE OF DEATH.

90E 59455

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2903 Willaz Ave ST., 27-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Carroll.

(a) RESIDENCE NO 2903 Willaz Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Rosa L. Carroll.

6 DATE OF BIRTH (month, day, and year) Aug 18th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brush Mfg. 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Sinclair D. Carroll

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Emily White

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Rosa L. Carroll. (Address) 2903 Willaz Ave

15 Filed 1930 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1st 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 15th, 1930. to Aug 1st, 1930. that I last saw him alive on July 31st, 1930 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows: Chronic myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) A. L. Gordy. M. D.

8-2. 1930 (Address) Harford & Overland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Aug 4 1930

20 UNDERTAKER Chas. H. Black ADDRESS 742 W. North Ave

E 59456

HEALTH DEPARTMENT—CITY OF BALTIMORE

183 E 59456

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Agnes Hospital ST. 7-1-75 WARD X

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond J Meekins

(Residence in Baltimore: No. Woodlawn Md St.; yrs., mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug (Month) 18 (Day), 1812 (Year)

7-AGE, 17 yrs. 11 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farm Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... Farm

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Raymond J Meekins

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Margaret Smoot

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond J Meekins

(Address) Woodlawn Md

15- 1930 C. HAMPSON JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 2 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractura neck of femur dying in Stallard Hospital

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Chas. H. Brodie M. D. (Coroner.)

Aug. 3, 1930 (Address) Brooklyn Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL Woodlawn Cem DATE OF BURIAL, Aug 5, 1930

20-UNDERTAKER Mr Elsie Armstrong ADDRESS George L. Johnson 210 Cook Ave

...c.—1-30—M. & T.—250 Bks

59457

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37

E 59457

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4223 Seidel Ave ST. [illegible] WARD)

2-FULL NAME Mary Schwarzenberg

(a) RESIDENCE No. 4223 Seidel Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Schwarzenberg

DATE OF BIRTH (month, day, and year) July 30 1906

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24		3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house wife

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pennsylvania

10 NAME OF FATHER Joseph Holiskey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Kompom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

Informant William Schwarzenberg

(Address) 4223 Seidel Ave Husband

Filed 1930, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2/1930

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1930, to Aug 2, 1930, that I last saw h[illegible] alive on July 31, 1930, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Congenital Endocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J Wade, M. D.

8/3, 1930 (Address) 936 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Cmty

DATE OF BURIAL Aug 5 1930

20 UNDERTAKER Lilly & Zeiler Inc

ADDRESS 403 S Wolfe

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 16-23 101-001 E 59458

~~59458~~

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 E. Carey ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Savage

(a) RESIDENCE NO. 1122 E. Carey ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Savage

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	49	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 640

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co.

PARENTS

10 NAME OF FATHER George W. Savage

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country)

12 MAIDEN NAME OF MOTHER Josephine Blair

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country)

14 Informant Lillian Savage (Address) 1122 E. Carey St.

15 Filed Aug 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to Aug. 1, 1930, that I last saw h[illegible] alive on Aug. 1, 1930, and that death occurred, on the date stated above, at 6:15 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Dg.

(Signed) William H. Tong M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudenslager, Balto. Md.

DATE OF BURIAL Aug 3 1930

20 UNDERTAKER Thomas Co Kelam

ADDRESS 1303 Eastern Ave

sc.—1-30—M. & T.—250 Blks.

E 59459

E. 59459

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59459

CERTIFICATE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH South Balto Gen. Hospital

CITY OF BALTIMORE: (NO. ..... ST. 624 (WARD) 23

2-FULL NAME Mrs Mary Gillingham

(a) RESIDENCE NO. Naval Academy Junction ST., ... WARD ..... , Maryland
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Charles C Gillingham

DATE OF BIRTH (month, day, and year) March 25 [illegible]

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	4	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Stephen A Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma L Cadwallader

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant Hospital Records
(Address)

Filed AUG 4 1930 C. HAMILTON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-3-30

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to August 3, 1930,

that I last saw her alive on August 3, 1930

and that death occurred, on the date stated above, at 420 Am.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
& diabetes (1+ yr. duration)

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Acute cardiac decompensation (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs & symptoms

(Signed) Joseph J. Lankester M. D.

, 19 (Address) South Baltimore Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interim

DATE OF BURIAL 8/5 1930

20 UNDERTAKER William Cook

ADDRESS 1217 E Pratt St

Rec.—1-30—M. & T.—250 Blks

59460

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001

E 59460

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2129 ST., WARD)

2-FULL NAME Anna Wilson

(a) RESIDENCE No. 1618 N. Henry ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elmer

DATE OF BIRTH (month, day, and year) July 14th 1898

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	0	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

BIRTHPLACE (city or town)
(State or country) Md

10 NAME OF FATHER John Fugate

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Ida Bull

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

Informant Husband
(Address)

Filed 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-2-30

17 I HEREBY CERTIFY, That I attended deceased from 7-10, 1930, to 8-2, 1930, that I last saw her alive on 8-2, 1930, and that death occurred, on the date stated above, at 8 45 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cholecystitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 8/2/30 AM

Was there an autopsy? No

What test confirmed diagnosis? Clinical - operation

(Signed) J. Leyko M. D.

8/2, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 8/5 1930

20 UNDERTAKER Wm Cook

ADDRESS 1317 St Paul

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59461

CERTIFICATE OF DEATH

179 E 59461

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Joseph's Hospital St., Ward)

2-FULL NAME Mary Jane Sheubrooks 9-47

(a) RESIDENCE NO. 821 Cator Avenue St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. 28 ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Oct. 5, 1928

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	1	9	28 27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. R. Sheubrooks

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Bessie L. Fairbanks

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Wm. R. Sheubrooks
(Address) 821 Cator Avenue

15 Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia with malaria

Burns of 3rd Degree

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 821 Cator Ave

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 8/5 1930

20 UNDERTAKER Henry C. Pears

ADDRESS 1805 W. Calvert

...—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 59462

E 59462

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 N. Monroe ST. 1627 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irvin L. McLaughlin,

(a) RESIDENCE NO. 1004 N. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Ida Esther McLaughlin,

DATE OF BIRTH (month, day, and year) June 11, 1889

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
41	1	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Charles McLaughlin,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ella Coulter,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

Informant Mrs Ida E. McLaughlin

(Address) 1004 N. Monroe St

Filed AUG 4 - 1930 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) AUG 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Aug 2, 1930,

that I last saw him alive on Aug 1, 1930

and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ulcer stomach

(duration) 3? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of about 2 years ago.

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam.

(Signed) Louis T. Levy, M. D.

8/3, 1930 (Address) 1844 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL AUG 5 1930

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59463

CERTIFICATE OF DEATH.

44

E 59463

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 Llewelyn St.: 8-17 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Durall

(a) RESIDENCE. No. 1707 Llewelyn St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Durall

6 DATE OF BIRTH (month, day, and year): July 6. 1867

7 AGE: Years 63; Months; Days 25; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): O'Neill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D.C

PARENTS

10 NAME OF FATHER: McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country): D.C

12 MAIDEN NAME OF MOTHER: Lizzie Durall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): D.C

14 Informant (Address): Daughter Alice Gross 1707 Llewelyn ave

15 Filed 4-1930 by H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 22nd, 1929, to Aug. 1st, 1930

that I last saw him alive on Aug. 1st, 1930

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Coma

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob L Lehner, M. D.

8-3, 1930 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem.

DATE OF BURIAL: Aug. 4. 1930

20 UNDERTAKER: Mrs. F. G. Locke

ADDRESS: 1302 Jefferson

...ec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59464

CERTIFICATE OF DEATH.

131 E 59464

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 Bruce ST., 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Johnson

(a) RESIDENCE NO. 1117 Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Lavinia Johnson

DATE OF BIRTH (month, day, and year) 1889

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Funeral Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto City

10 NAME OF FATHER Harry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Wilkerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Earl Dorsey

(Address) 1117 Bruce

15 Filed Aug 5 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2, 30

17 I HEREBY CERTIFY, That I attended deceased from July 29, 19 30 to August 2, 19 30

that I last saw h[illegible]alive on August 2, 19 30

and that death occurred, on the date stated above, at 8 A.M. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis

(Signed) A. Lee Gibbs, M. D.

, 19 30 (Address) 324 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Aug 5 1930

20 UNDERTAKER John H Toadvine

ADDRESS 1027 Druid Hill

Spec.—1-10-21—M&T—1500 Bks.

E 59465

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 59465

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Edmondson Av ST. 17-16 WARD)

2-FULL NAME Mary Ballard

(a) RESIDENCE NO. 906 Edmondson Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Ballard

6 DATE OF BIRTH (month, day, and year) Feb 12 1848

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
82	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Princess Anne Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Princess Anne (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) Princess Anne (State or country) Md

14 Informant Elizabeth Blake

(Address) 528 N Arlington Av

C. HARRISON JONES, M. D.

Filed AUG 4 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1930

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1930, to Aug 1, 1930,

that I last saw her alive on July 31, 1930

and that death occurred, on the date stated above, at 8 40 a. m. E Standard Time

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

+ Senility

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Senility

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H P Hughes, M. D.

8/2, 1930 (Address) 825 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvery

DATE OF BURIAL Aug 4 1930

ADDRESS 1027

20 UNDERTAKER John H. Trodvin

Mund Hill

-30—M. & T.—100 B—501.

59466

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 59466

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp (ST.) 15-23 (WARD)

2-FULL NAME Harry Bessick

(a) RESIDENCE NO 1333 W. Stockton WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) 0/0
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charleston S.C.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Harry Bessick

(Address) 1040 N. Mundo

15 Filed ..... 1930 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH was as follows: Acute Dilatation of Heart

..... (duration) ..... yrs. Sudden

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) A. B. Clark M. D. Coroner

(Address) May 2

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 4 1930

UNDERTAKER Virginia A. Brooke ADDRESS 1463 N. Carey

HARRY JONES, M. D.

Rec.—1-30—M. & T.—250 Blks

59467

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 59467

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 16 WARD)

2-FULL NAME Mary Alice Conway

(a) RESIDENCE NO. 1027 Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Not known

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Jerry Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eva Spence

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Eva Conway (Address) 1027 N. Stricker St

15 Filed 4 1930 HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-30-30

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to July 30, 1930, that I last saw her alive on July 30, 1930, and that death occurred, on the date stated above, at 11:55 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Primary)

(duration) about 2 mos 12 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Aug 4 1930

20 UNDERTAKER Virginia A Brooks ADDRESS 1463 N. Caseys St

...c.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59468

CERTIFICATE OF DEATH

90 E 59468

1—PLACE OF DEATH Maryland Gen. Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 21 W. (Ward)

2—FULL NAME Henry Frey

(a) RESIDENCE NO. 1107 Warner ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) July 1877

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
53		1		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER Frederick Frey

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Minn Soety

13 BIRTHPLACE OF MOTHER (city or town) Md. Balto. (State or country)

Informant Hospital Records.

(Address)

Filed 4-1930, H. A. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2- 30

17 I HEREBY CERTIFY, That I attended deceased from 7-31-, 1930, to 8-2-, 1930, that I last saw h... alive on 8-2-, 1930 and that death occurred, on the date stated above, at 6:30 A m. Std.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

arteriosclerosis

(duration) 2 yrs. or longer mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unk.

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Path. Lab.

(Signed) Calvert H. Chenault, M. D.

, 19 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Bethlaem	Aug 5 1930
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59469

CERTIFICATE OF DEATH. 144

E 59469

REGISTERED NO. 13559

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (Ward)

2-FULL NAME Marian Diggs

(a) RESIDENCE NO. 2662 Flora ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: B

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of John C. Diggs

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE: Years 28; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

PARENTS

10 NAME OF FATHER J. Diggs

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hattie Pindell

13 BIRTHPLACE OF MOTHER (city or town) Annapolis (State or country) Md

14 Informant Husband (Address)

15 Filed [illegible] 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1930, to Aug 7, 1930, that I last saw h[illegible] alive on Aug 7, 1930, and that death occurred, on the date stated above, at 10.55 P. m.

The CAUSE OF DEATH* was as follows: Postpartum Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Retained Placenta

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uterus & Clinical Findings

(Signed) W. Alexander Lowry M. D.

8/7, 1930 (Address) University Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 8/6/1930

UNDERTAKER Geo. H. Holland

ADDRESS 1601 Druid Hill

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59470 (1)

REGISTERED NO. E 59470

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (WARD) 16-23

2-FULL NAME Robt Matthews

(a) RESIDENCE No. 1107 Druid Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 Yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): Mar 17-1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	4	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Washington D.C.

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Henry Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Minnie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Allen Matthews

(Address): Washington D.C.

15 Filed 4-1930 (192) HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptured Appendix (duration) yrs. mos. 1 da.

Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Regular

(Signed) M. D. Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D. C.

DATE OF BURIAL: 8/4/1930

ADDRESS

UNDERTAKER: Mrs. Geo. H. Holland 1631 D

...ec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59471

X 161-001

E 59471

CERTIFICATE OF DEATH

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Fayette & Calhoun ST., 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Roche

(a) RESIDENCE NO. Stemmers Run Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

DATE OF BIRTH (month, day, and year) July 31 1930

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		3 ✓	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Peter Rosche

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Helen Horan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Mr. Roche

(Address) Stemmers Run Md

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-3-30

17

I HEREBY CERTIFY, That I attended deceased from 7-31-30, 19..., to 8-3, 19 30,

that I last saw her alive on 8-3-, 19 30

and that death occurred, on the date stated above, at 6:10 P m.

The CAUSE OF DEATH* was as follows:

Respiratory Failure

from intoxication

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Prematurity & nephritis

of mother (duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? Franklin Square Hospital

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) M. B. Schreiber, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakdown Cemty DATE OF BURIAL Aug. 4, 1930

20 UNDERTAKER John A. Moran ADDRESS 3000 E Balto St.

Spec.—1-30—M. & T.—350 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59472

CERTIFICATE OF DEATH.

164 E 59472

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 E. 22d ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora J. Deal

(a) RESIDENCE NO. 814 E. 22d ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Deal

DATE OF BIRTH (month, day, and year) Jan. 1 1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	8	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) West Virginia

10 NAME OF FATHER Edmond Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

PARENTS

14 Informant Edward Deal (Address) 814 E. 22nd St.

15 Filed 4 1930, 19 C. HUMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1930, to Aug. 3rd, 1930, that I last saw him alive on Aug. 3rd, 1930, and that death occurred, on the date stated above, at 2.20 A. m.

The CAUSE OF DEATH* was as follows:

Intussusception of Age.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. H. Magruder M. D.

(Address) 14. E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL aug 6 1930

UNDERTAKER George W Zickler

ADDRESS 1737 Eager St.

spec.—1-30—M. & T.—250 Bks

59473

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

88

REGISTERED NO. 59473 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto City Hosp ST., 26-37 WARD)

2-FULL NAME Emma Reynolds

(a) RESIDENCE NO. 629 S. Lehdyr ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar Reynolds.

DATE OF BIRTH (month, day, and year) Sept 15, 1877

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	3	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany.

10 NAME OF FATHER John Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ~

14 Informant Hospital Records.

(Address)

Filed Aug 4 1930

C. Hastings JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-3-30

17 I HEREBY CERTIFY, That I attended deceased from 7-31, 1930, to 8/3/, 1930, that I last saw her alive on 8/3/, 1930, and that death occurred, on the date stated above, at 5:25 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Acute

(duration) yrs. 2 mos 7 ds.

CONTRIBUTORY (Secondary) ~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Jas G. Hundley Jr. M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Aug 6 1930
20 UNDERTAKER George W. Zirkler	ADDRESS 1737 Eager

Dec.—2-29-28—L. F. S.—500 Bks.

E 59474

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 59474

CERTIFICATE OF DEATH

100-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2258 Cecil Av ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John M. Fetsch

(a) RESIDENCE NO. 2258 Cecil Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) May 8, 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	26 25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Edgar L Fetsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Nellie Fallon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

Informant Nellie Fallon

(Address) 2258 Cecil Av

C. HARPER JONES, M. D. Registrar

Filed AUG 4 1930, 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Aug 3, 1930

that I last saw h alive on Aug 3, 1930

and that death occurred, on the date stated above, at 5 45 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) Jno. B. Sykes M. D.

, 19 (Address) 2802 Harford Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Aug 4 1930

ADDRESS 301 E 22nd St

20 UNDERTAKER E C Mary M Nudsfield

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59475

CERTIFICATE OF DEATH.

58-001

59475

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 818 W. 40th St. ST., 12-52 WARD)

2-FULL NAME Jane M. Kimball

(a) RESIDENCE NO. 818 N. 40th St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

If married, widowed or divorced HUSBAND of (or) WIFE of Richard F. Kimball

DATE OF BIRTH (month, day, and year) Aug 1 1858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	0	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) Balto (State or country) Md

10 NAME OF FATHER Edw. F. Norris

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Annie Wilson

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

Informant Edward N. Kimball

(Address) 627 Deepdene Rd.

Filed Aug 4 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3d 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug ..., 1928, to Aug 3, 1930, that I last saw h[illegible] alive on August 2, 1930, and that death occurred, on the date stated above, at 12.20 A m.

The CAUSE OF DEATH* was as follows: Combined Postero-Lateral sclerosis with Pernicious Anemia

Onset (duration) 6 yrs. ✓ mos — ds.

CONTRIBUTORY (Secondary) ✓ (duration) — yrs. ✓ mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Geo Wm Arp, M. D.

Aug 4, 1930 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount

DATE OF BURIAL Aug 5 1930

ADDRESS McCulloh - Orchard Sts

UNDERTAKER Henry H. Jenkins Sons

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59476

CERTIFICATE OF DEATH.

129 E 59476

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 N Caroline ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Green

(a) RESIDENCE NO. 306 N Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of Frances Green

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lucy —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Green wife (Address) 306 N Caroline st

15 Filed AUG 4 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1930

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to July 1, 1930.

that I last saw h alive on July 31, 1930.

and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Chr. Pneumonia Influenza

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Enteritis Colitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. J. Sparks, M. D.

8/2, 1930 (Address) 1129 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lion Cem DATE OF BURIAL 8/6 1930

UNDERTAKER Daniel Easton ADDRESS 916 Park

pec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

33 E 59477

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 59477

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto City Hosp. ST. 15-21 (WARD)

2-FULL NAME Allen Jackson

(a) RESIDENCE NO. 1730 Baker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C.	single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

7 DATE OF BIRTH (month, day, and year) Aug 5, 1914

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	11	27	

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

10 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

11 NAME OF FATHER J. H. Jackson

12 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

13 MAIDEN NAME OF MOTHER Lillian Evans

14 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

15 Informant Hospital Records.
(Address) .....

Filed 1930 C. HAMILTON JONES, M. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-2-30

17 I HEREBY CERTIFY, That I attended deceased from 7-28, 1930, to 8-2, 1930, that I last saw him alive on 8-2, 1930, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:
Plastic Peritonitis, Tuberculous.
(duration) ..... yrs. 4 mos ..... da.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What tests confirmed diagnosis? .....

(Signed) Jas. L. Gilmour M. D.

19 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

20 UNDERTAKER Daniel Zantzinger

DATE OF BURIAL 8/4 1930

ADDRESS 916 Park

1-30—M. & T.—100 B—501.

59478

HEALTH DEPARTMENT—CITY OF BALTIMORE

B E 59478

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1132 Shields Alley ST., WARD)

2-FULL NAME Doris Lockerman

(a) RESIDENCE NO 1132 Shields ST., 17th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Col	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 21 29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Elbert Flora Lockerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ethel Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ethel Lockerman

(Address) 1132 Shields Alley

15 Filed Aug 2 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) 2 yrs 1 mos 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? 1132 Shields alley

Did an operation precede death? — Date of —

Was there an autopsy? Thy Ex

What test confirmed diagnosis? 1430

(Signed) J. C. Gladden, M. D. Coroner

(Address) 1432 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lo Cem

DATE OF BURIAL 8/4 1930

UNDERTAKER Lane Eustis

ADDRESS 916 Pa

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59479

CERTIFICATE OF DEATH

90

59479

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 7 E. York St. St. 22-20 Ward)

2-FULL NAME Isabelle Carter. (C)

(a) RESIDENCE NO. 7 E. York St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widow.

5a If ~~single~~, widowed, ~~or divorced~~ (or) WIFE of Edward Carter. (C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	60	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Iverson Braxon. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Fannie Johnson. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Virginia E. Carter. (C) daughter
(Address) 7 E. York St.

Filed 8-4 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardiol Insufficiency.

(duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

8/4, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion ct. DATE OF BURIAL Aug 4 1930

20 UNDERTAKER C. A. Brown & Son ADDRESS 1011 W. Mulberry

Page

pec.—1-30—M. & T.—250 Bks

E 59480 HEALTH DEPARTMENT—CITY OF BALTIMORE 45 E 59480

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 W 33rd St. ST., 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry G. Rogers.

(a) RESIDENCE NO. 705 W 33rd St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie C. Rogers.

7 DATE OF BIRTH (month, day, and year) Nov 6, 1880

8 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	8	26.	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor 073

(b) General nature of industry, business, or establishment in which employed (or employer) Penna. R. R.

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Wm. H. Rogers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Emma J. Hershey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Carrie C. Rogers.

(Address) 705 W 33rd St

15 Filed 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929 to Aug 2, 1930, that I last saw h[illegible] alive on Aug 2, 1930, and that death occurred, on the date stated above, at 11 55 A.m.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage.

(Bladder & Rectum.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum & Bladder

(duration) 1 yrs. mos. ds. 0 0 2 1

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Frank J. Hurley, M. D.

, 19 (Address) 4037 Falls Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 5 1930
20 UNDERTAKER	ADDRESS
Ehrenwerth Son	2405 Eutaw Pl

Spec.—1-30—M. & T.—250 Blks.

59481

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 59481

1-PLACE OF DEATH (a) CITY OF BALTIMORE: (No. University Hospital 1830 St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arch Wilson.

(a) RESIDENCE NO. Richwood West Virginia WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Palmer Wilson

7 DATE OF BIRTH (month, day, and year) Jan 29-1875

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 056

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Va

10 NAME OF FATHER Jordan Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Va

12 MAIDEN NAME OF MOTHER Mollie Shallis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant Mrs E A Thompson (Address) West Va

15 Filed ... 1930 ... (Signature of Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 29th, 1930, to August 4th, 1930, that I last saw h[illegible] alive on August 4th, 1930, and that death occurred, on the date stated above, at 3.35 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Secondary Anemia

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Lab data + autopsy

(Signed) Geo Yeager, M. D.

Aug 4, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richwood West Va

DATE OF BURIAL 8/4 1930

20 UNDERTAKER Robt Brooke & Son

ADDRESS Calhoun Hollis

Cor.—10-10-29—A Co.—100 Bks.

Kabat

HEALTH DEPARTMENT—CITY OF BALTIMORE

9482

CERTIFICATE OF DEATH

90 E 59482

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 522 S. Washington St., 2-4 Ward)

2-FULL NAME Mary Kabat

(a) RESIDENCE NO. 522 S Washington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30 1853

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	37	11	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pharmacist
(b) General nature of industry, business, or establishment in which employed (or employer) Calvert Bldg
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Vincent Kabat

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Rosa Thomas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Joseph Kabat
(Address) 522 S Washington St

15 Filed ..... 19.. L. HARRISON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: 1

Mitral insufficiency
& dilatation of Heart

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Rheumatism

(duration) yrs. 1 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M. Fenton M. D.

8/3/1930 (Address) 700 E Chase

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Aug 6 1930
20 UNDERTAKER	ADDRESS
John M Weber	1012 Chester

4 - 1930

E 59483

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59483

CERTIFICATE OF DEATH.

185

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3125 Pulaski St., 10-69

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George D. Muench

(Residence in Baltimore: No. 3125 Pulaski St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	W	Widower

6-DATE OF BIRTH. Oct. (Month) 15 (Day) 1845 (Year)

7-AGE. 85 yrs. 4 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Retired

9-BIRTHPLACE. (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Geo Muench

(Address) 3125 Pulaski

15- Filed Aug 4 - 1930 192 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug (Month) 3 (Day) 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident - Fell down Steps Internal injuries

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas. T. Brooke M. D. (Coroner.)

Aug 3 1930 (Address) Brooklyn

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park DATE OF BURIAL. 8/5/1930

20-UNDERTAKER. Geo. Weber & Son ADDRESS 2503 Edmondson Ave

Spec.—2-29-28—L. F. S.—500 Bks.

Yvonne N. Williams

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59484

CERTIFICATE OF DEATH X 32

E 59484

REGISTERED NO. 23-31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number) formerly: 15 D St. S.E. Washington D.C.

2—FULL NAME Yvonne Naomi Williams

(a) RESIDENCE NO. 909 1/2 Fearenhall ST., 23rd WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) July 24, 1928

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	0	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Washington, D.C.
(State or country)

10 NAME OF FATHER Jefferson J. Williams

11 BIRTHPLACE OF FATHER (city or town) Talbot County
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lottie Hardy

13 BIRTHPLACE OF MOTHER (city or town) Woodville
(State or country) D.C.

14 Informant Jefferson J. Williams
(Address) 909 1/2 Fearenhall St.

15 Filed ... 19 C. HAMPSON JONES, M.D.
Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1930, to Aug. 1, 1930.
that I last saw h... alive on Aug. 1, 1930
and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Tubercular Cerebrospinal Meningitis

(duration) 0 yrs. 0 mos. 31 ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Washington, D.C.

Did an operation precede death? No Date of ...

Was there an autopsy? No What test confirmed diagnosis? Clinical and Laboratory

(Signed) Joseph H. Strain, M.D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Aug 4 1930

20 UNDERTAKER Walter B. Spriggs

ADDRESS 139 W. Hamburg St.

Spec.—1-30—M. & T.—250 Blks

E 59485 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-002 E 59485

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Clarke

(a) RESIDENCE NO. 1342 Homestead Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (Month, day and year) August 2, 1930

7 AGE	Months	Days	If LESS than 1 day, hrs. or min.
24 hrs	—	— 1	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John S. Clark.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Helen McCaskey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. J. Clark (Address) 1342 Homestead Ave.

15 Filed 6-4-1930 H. C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 2, 1930 to August 3, 1930, that I last saw h[illegible] alive on August 3, 1930, and that death occurred, on the date stated above, at August 3 m. 4:01 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

over

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. Byers Waynderfer M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 8/4/1930

20 UNDERTAKER C. D. Fanning & Son - 1928 E. Lafayette Ave

ADDRESS

Spec.—1-30—M. & T.—250 Blks

59486

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 E 59486

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6231 York Road St. 27-46 WARD

2-FULL NAME Elizabeth Virginia Tapscott

(a) RESIDENCE NO. 6231 York Road St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed or divorced HUSBAND of (or) WIFE of Franklin Muir Tapscott

6 DATE OF BIRTH (month, day, and year) Dec 19 1889

7 AGE: Years 40 | Months 9 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry B Humphreys

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma L Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Franklin M Tapscott

(Address) 6231 York Road

15 Filed AUG 4 - 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1930, to Aug 2, 1930,

that I last saw her alive on Aug 2, 1930,

and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

6

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 7/30

Was there an autopsy? No What test confirmed diagnosis? Microscopical

(Signed) Fr. J. Stockman, M. D.

(Address) 5835 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Aug 5 1930

20 UNDERTAKER: H. Rudon Sons — ADDRESS: Md Pa

Spec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

59487

CERTIFICATE OF DEATH.

44 E 59487

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2603 Huntingdon ST., 17th WARD)

2-FULL NAME George Simon Binder

(a) RESIDENCE NO. 2603 Huntingdon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Binder

6 DATE OF BIRTH (month, day, and year) May 3 - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of Industry, business, or establishment in which employed (or employer) 078

(c) Name of employer U E. R. Co

9 BIRTHPLACE (city or town) Dorsey Md
(State or country)

PARENTS

10 NAME OF FATHER George S. Binder

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Henry Dr Zuart
(Address) 2623 Huntingdon

15 Filed Aug 4 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1930, to Aug 3, 1930, that I last saw him alive on Aug 2 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Abdominal Carcinoma
Primary in Stomach

(duration) 1 yrs. 2 mos da.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray exam

(Signed) Hubert C Knapp, M. D.

8/4, 1930 (Address) 1716 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dorsey Howard Co

DATE OF BURIAL Aug 5 1930

20 UNDERTAKER J. J. Beckmeyer Sons

ADDRESS Monkton

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59488 — 194 — E 59488

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Chadford Apts ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Labordere Fisher

(a) RESIDENCE NO. Chadford Apts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 7 mos. 7 ds. How long in U. S., if foreign birth? 73 yrs. 7 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of J. Harmanus Fisher

DATE OF BIRTH (month, day, and year) December-24-1836

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	93	7	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

BIRTHPLACE (city or town) Jeremie

(State or country) Hatii

10 NAME OF FATHER William L. McCulloh

11 BIRTHPLACE OF FATHER (city or town) ? ?

(State or country) Penna

12 MAIDEN NAME OF MOTHER Tallate Labordere

13 BIRTHPLACE OF MOTHER (city or town) ? ?

(State or country) France

14 Informant Mrs. Frank Fisher

(Address) 4414 Norwood Road.

Filed AUG 4 1930 H. [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3/30

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to Aug 3, 1930, that I last saw h[illegible] alive on Aug 1, 1930 and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows: Pneumonia R. Lung.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) R. Hem. plegia - Heart

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ed H Stewart M. D.

8/5, 1930 (Address) 6825 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL August 5/30

20 UNDERTAKER Stewart & Mowen Co. — ADDRESS 108 W. North Ave.

Cor.—10-10-29—A Co.—100 Bks.

59489

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59489

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Adopted Child Duvall Her name

City of Baltimore: (No. 1433 Eastern St. 325 Ward)

2-FULL NAME Edward Hunt

(a) RESIDENCE No. 1433 Eastern St., Ward

(usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	1	4		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Edward Hunt
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Malista Perry

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Ray Bernard Hunt
(Address) 1433 Eastern

15 Filed ..... 19.... Registrar

4-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease Chronic

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Hundley M. D.

(Address) 704 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery

DATE OF BURIAL 8/4/30. 19

20 UNDERTAKER George J. Pulliam

ADDRESS 1735 Harford

Important. See instructions on back of certificate.

Rev.—2-20-28—L. F. S.—600 Blks.

E 59490

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 594 45

CERTIFICATE OF DEATH

1—PLACE OF DEATH Maryland Gen Hosp REGISTERED NO. 9416

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leo P. O'Brien

(a) RESIDENCE NO. 2813 Green-Mount ave. ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Maried

a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Harrison O'Brien

DATE OF BIRTH (month, day, and year) June 24 1889

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
41	-	1	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 66

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER James Patrick O'Brien

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Bennett

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

PARENTS

14 Informant Hosp. Records (Address)

15 Filed AUG 4 - 1930 19 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/3/30

17 I HEREBY CERTIFY, That I attended deceased from 8/1, 1930, to 8/3, 1930, that I last saw him alive on 8/3/30, 1930, and that death occurred, on the date stated above, at 8:35 a.m. Std

The CAUSE OF DEATH* was as follows:

Carcinoma of Scrotum (Primary) with metastasis to Liver

1 yr. or more?

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Path-H.

(Signed) Robert T. Bennett, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/6 1930
UNDERTAKER	ADDRESS
Chas. F. Fraunfelter Son	1180 W. Royal ave

Spec.—1-30—M. & T.—250 Mks.

2 37 378
E 59491

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59491

X 132

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 7-9 WARD)

2-FULL NAME William Thomas

(a) RESIDENCE No. Cambridge, Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie

6 DATE OF BIRTH (month, day, and year) Feb. 15, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Landscape Gardener

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E Dail

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed 4-1930, 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4-1930

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1930, to Aug 4, 1930, that I last saw him alive on Aug 4, 1930, and that death occurred, on the date stated above, at 6 20 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia, bilat
Pyelonephritis, bilat
Uraemia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) ? Nephrolithiasis, bilat.
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 8/1/30

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) ..... M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md — DATE OF BURIAL 8/4 1930

20 UNDERTAKER William Cook — ADDRESS 127 Race

Spec.—1-30—M. & T.—200 Blks.

E 59492

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 59492

REGISTERED NO. 107

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2735 N. Charles ST., 12 WARD)

2-FULL NAME Frank Pearson Dyer

(a) RESIDENCE NO. 2735 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Sept. 1, 1856

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11	2	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Realtor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Washington, D.C

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER ~

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Charles A. Stauffer

(Address) 502 Chelsea Rd Roland Park

15 Filed 4-1930, 19 C. HAMPSON JONES, M. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 — , 1930, to — — , 19 ,

that I last saw him alive on Aug. 1, , 1930,

and that death occurred, on the date stated above, at 6:15A m.

The CAUSE OF DEATH* was as follows:

Abscess of Lung (Left) (Cover)

(duration) yrs. mos de.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Moses Raskin, M. D.

, 19 (Address) 2038 E Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 8/4 1930

20 UNDERTAKER Henry W Jenkins Sons

ADDRESS Orchard & Eutaw

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59493 — 49 — E 59493

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S. Marine Hospital ST., WARD 3)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Hill 74.3

(a) RESIDENCE NO. 305 E. Hamburg St. ST., Balto. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Margaret Mulligan

6 DATE OF BIRTH (month, day, and year) May 25, 1858

7 AGE	Years	Months	Days	If LESS than 1 day ~~Yrs.~~ hrs. ~~Min.~~
	72	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records

(Address) U. S. Marine Hospital

15 Filed 4 - 1930 C. HAMPSON JONES, M. D. Registrar Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1930, to August 3, 1930, that I last saw h.. alive on August 3, 1930 and that death occurred, on the date stated above, at 4:15 P.m. S.T.

The CAUSE OF DEATH* was as follows:

Carcinoma of right side of neck.

..... (duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation

(Signed) Gordon A. Abbott, M. D.

. 19 (Address) U. S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug. 6 - 1930

20 UNDERTAKER Margaret E. Flynn ADDRESS 1422 Eutaw Pl.

Spec.—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59494 ✓ E 59494

CERTIFICATE OF DEATH.

90

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 421 Rosecroft Ter. St., 20-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Mitchell

(a) Residence No. 421 Rosecroft Ter St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.): Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Edwin S. Mitchell

6-DATE OF BIRTH (month, day and year): Mar. 5, 1879

7-AGE: 51 yrs. 4 mos. 28 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Seamstress 069

(b) General nature of Industry, business, or establishment in which employed (or employer): Haywood Wakefield Co.

(c) Name of employer: Not employed in past 6 mo.

9-BIRTHPLACE (city or town) (State or Country): Balto., Md.

PARENTS.

10-NAME OF FATHER: Frank Stang

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto., Md.

12-MAIDEN NAME OF MOTHER: Mary Keller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto., Md

14- (Informant): Mrs. Pearl Lohman

(Address): 421 Rosecroft Ter.

15- FEB 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug. 2, 1930.

17- I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to Aug. 2, 1930.

that I last saw her alive on Aug. 2, 1930

and that death occurred, on the date stated above, at 11 15 a. m.

The CAUSE OF DEATH* was as follows:

chronic endocarditis

.....

.....

.....

.....(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) cardiac dilatation

.....(Duration) ... yrs. ... mos. 1 ds.

18-Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? usual tests

(Signed) George A. Kupp M. D.

, 19 (Address) 3030 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL, Aug. 5, 1930

20-UNDERTAKER: Margaret E. Flynn

ADDRESS 1417 Riggs Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59495

CERTIFICATE OF DEATH.

74-001

E 59495

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 Robert St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Braun

(a) RESIDENCE. (Usual place of abode) No. 540 Robert St., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha H Brown

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annandale Co. Md

PARENTS

10 NAME OF FATHER Benjamin Braun

11 BIRTHPLACE OF FATHER (city or town) Annandale Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Sally Braun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant W. G. Braun (Address) 540 Robert St

15 Filed 4-1930, H. HAMPSON JONES, Registrar M. D. By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4 1930

17 I HEREBY CERTIFY, That I attended deceased from August 4, 1930, to August 4, 1930, that I last saw h[illegible] alive on " " , 19 , and that death occurred, on the date stated above, at 12.01 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage & Softening

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles T. Woodland, M. D.

, 19 (Address) 1205 Myrtle Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cem. DATE OF BURIAL: Aug 7 1930

20 UNDERTAKER: Geo. T. C. Gibson ADDRESS: 1735 W. Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59496

CERTIFICATE OF DEATH

11-00 | E 59496

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1336 E Fort Ave St., 7 4 35 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George N. Brungel.

(a) RESIDENCE NO. 1336 E. Fort Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2nd 1928

7 AGE: Years 2 | Months 2 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Nicholas Brungel.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mustad Hungary

12 MAIDEN NAME OF MOTHER Caroline Blum.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria Hungary.

14 Informant: Caroline Brungel (Mother)

(Address) 1336 E. Fort Ave

15 Filed AUG 4th 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3-30

17 I HEREBY CERTIFY, That I attended deceased from July 23. 19 30. to August 3 19 30

that I last saw him alive on August 2, 19 30

and that death occurred, on the date stated above, at 1 40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? X Ray.

(Signed) Thos. Fo Stevens, M. D.

8/3, 19 30 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross M. A. Co. Md.

DATE OF BURIAL: Aug 5. 1930

20 UNDERTAKER: Thos. R. Sivrins

ADDRESS: 1301 East Ave

Spec.—1-30—M. & T.—250 Blks

Alvin R Brown ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59497 23 E 59497

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mercy Hospital ST. 27 26 WARD)

2-FULL NAME Alvin R. Brown

(a) RESIDENCE NO. 2916 Edgecomb circle ST., Edgecomb Circle WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Brown

6 DATE OF BIRTH (month, day, and year) June 3rd, 1883

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
47	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street Car Conductor 078

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railway & Electric Co.

9 BIRTHPLACE (city or town) (State or country) Kent County Md

PARENTS

10 NAME OF FATHER Samuel Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent County Md

12 MAIDEN NAME OF MOTHER Agista B. Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Hospital Records (Address) C. HARRISON JONES, M. D.

15 Dec. 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-4-30

17 I HEREBY CERTIFY, That I attended deceased from 7-26, 1930, to 8-4, 1930, that I last saw him alive on 8-4, 1930, and that death occurred, on the date stated above, at 4.50 A. m.

The CAUSE OF DEATH* was as follows:

Acute Epidemic Encephalitis

(duration) yrs. mos 22 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyko, M. D.

Aug. 6, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown, Md.

DATE OF BURIAL Aug. 6 1930

20 UNDERTAKER Leonard Cook

ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59498 146 E 59498

CERTIFICATE OF DEATH

REGISTERED NO. 27-46

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5806 Clear Spring Road, WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Funk

(a) RESIDENCE NO. 5806 Clear Spring Road WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert G. Funk

6 DATE OF BIRTH (month, day, and year): Dec. 15th. 1896

7 AGE: Years 33 | Months 7 | Days 17 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: At Home

9 BIRTHPLACE (city or town): Baltimore
(State or country): Maryland

PARENTS

10 NAME OF FATHER: George Bouldin

11 BIRTHPLACE OF FATHER (city or town): Baltimore
(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mollie E. Meyers

13 BIRTHPLACE OF MOTHER (city or town): Baltimore
(State or country): Maryland

14 Informant: Robert G. Funk
(Address): 5806 Clear Spring Road

Aug 4 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August, 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1930, to Aug-2-, 1930, that I last saw her alive on Aug-2-, 1930 and that death occurred, on the date stated above, at 6.45 P.m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs., mos. 30 ds.

CONTRIBUTORY (Secondary): Puerperal Septicaemia

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Bacteriological

(Signed) H C Hess, M. D.

Aug 3, 1930 (Address) 5600 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery DATE OF BURIAL: Aug. 5, 1930

20 UNDERTAKER: Lloyd D. Cook ADDRESS: 1003 N. Chase

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59499

CERTIFICATE OF DEATH

129 V E 59499

1—PLACE OF DEATH 119 S. Calhoun St — REGISTERED NO. 19-28

CITY OF BALTIMORE: (No. EDWIN R. DIFFENDERFER ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Diffenderfer

(a) RESIDENCE NO. 119 S Calhoun St. WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 4 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	7	30 29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Fowler Bros & Lawrence Wholesale Corp

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER James F Diffenderfer
11 BIRTHPLACE OF FATHER (city or town) Manchester
(State or country) Md
12 MAIDEN NAME OF MOTHER Mary A Turner
13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Son
(Address) 119 S Calhoun St

15 Filed ..., 19... By C. HAMPSON JONES, M. D. Registrar

7 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-3-30

17 I HEREBY CERTIFY, That I attended deceased from 7-26, 1930, to 8-3, 1930, that I last saw him alive on 8-3, 1930 and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:
Hypertensive Cardio-vascular disease with nephritis
(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

8 4 1930 (Signed) C. N. Peake, M. D. (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt Lookout Cem — DATE OF BURIAL Aug 6" 1930

20 UNDERTAKER Joseph S Cook — ADDRESS 1003 N Eutaw St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59500 88 E. 59500

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1320 Mosher ST. 16-23 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elijah Phillips

(a) RESIDENCE NO. 1320 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith

6 DATE OF BIRTH (month, day, and year) ? 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William E. Phillips (Address) 1320 Mosher St

4 [illegible] 03 HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/3/1930

I HEREBY CERTIFY, That I attended deceased from 7/7/1930, to 8/2/1930, that I last saw h[illegible] alive on 8/2/1930 and that death occurred, on the date stated above, at 8. A. m

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) — yrs. — mos 27 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. M. Lawrence M. D.

, 19 (Address) 1232 Mosher Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 8/5/1930

20 UNDERTAKER Geo. H. Holland

ADDRESS 1631 Druid Hill Ave

Spec.—1-30—M. & T.—250

E 59501

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59501

160

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 Fawcett St ST., 12 WARD)

2. FULL NAME Wm. F. Mc Govern.

(a) RESIDENCE NO. 440 Fawcett St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 11 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md.
(State or country)

10 NAME OF FATHER Wm. F. Mc Govern

11 BIRTHPLACE OF FATHER (city or town) md.
(State or country)

12 MAIDEN NAME OF MOTHER Ida Johnson

13 BIRTHPLACE OF MOTHER (city or town) md.
(State or country)

14 Informant Wm. F. Mc Govern
(Address) 440 Fawcett St.

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1930, to Aug 4, 1930.

that I last saw him alive on Aug 3, 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Icterus neonatorum

(duration) yrs. 2 mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) [illegible], M. D.

8/4, 1930 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden

DATE OF BURIAL Aug 5, 1930

20 UNDERTAKER Edmonds Olon

ADDRESS 3610 Chestnut Ave

Spec.—1-30—M. & T.—200 Stelios M. Pamfilis

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59502 E 59502

CERTIFICATE OF DEATH. 74-001

REGISTERED NO. 4-25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 N. Greene St. ST., 4-25 WARD)

2-FULL NAME Stelios M. Pamfilis

(a) RESIDENCE NO. 305 N. Greene St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Lemonia S. Pamfilis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) D50

(c) Name of employer

9 BIRTHPLACE (city or town) Greece
(State or country)

10 NAME OF FATHER Manuel Pamfilis

11 BIRTHPLACE OF FATHER (city or town) Greece
(State or country)

12 MAIDEN NAME OF MOTHER Katerina D. Papanicolaou

13 BIRTHPLACE OF MOTHER (city or town) Greece
(State or country)

14 Informant Lemonia Pamfilis
(Address) 305 N. Greene St.

15 Filed ..... C. HAMPSON JONES, M. D. Registrar
1930 By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4, 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1930. to Aug 4, 1930.
that I last saw him alive on June 3, 1930.
and that death occurred, on the date stated above, at 7.50 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) John D. Peden M. D.

8/7, 1930 (Address) 936 Monument E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Aug 6 1930

20 UNDERTAKER Chesnuth Son

ADDRESS 3615 Ft

Spec.—1-30—M. & T.—350 Bks.

Deuk.

E 59503 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59503

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Eden St., WARD) 8/17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Deuk

(a) RESIDENCE NO. 1803 N Wolfe St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of George T. Deuk

6 DATE OF BIRTH (month, day, and year) 9-8-1889

7 AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
40	10	28 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Md.

10 NAME OF FATHER August Kahler

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Kahler

13 BIRTHPLACE OF MOTHER (city or town) Balto Co (State or country) Md

14 Informant George T. Deuk (Address) 1803 N. Wolfe St

15 Filed 1930 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5-30

17 I HEREBY CERTIFY, That I attended deceased from 7-29-30, 19..., to 8-5-30, 19..., that I last saw h[er] alive on 8-5-30, 19..., and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cancer

Left Breast

(duration) ... yrs. 4 mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Yes Date of 7/30/30

Did an operation precede death? Yes Date of 7/30/30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) N B Handley, M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 8/8/30

20 UNDERTAKER George T. Deuk Sons

ADDRESS 1735 Harford

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59504

CERTIFICATE OF DEATH

90

E 59504

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 930 N. Augusta St., 10-14 Ward)

2-FULL NAME Bennie Beamer

(a) RESIDENCE NO. 930 N. Augusta St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE: Years 38 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mary Johnson
(Address) 525 Madison St

15 Filed ..... 19 ..... Registrar

5-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and upon and from the evidence obtained by said Inquest and from (Autopsy or inquest) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Autopsy

(Signed) G. C. Grades, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Aug 5 1930

20 UNDERTAKER: Samuel Stanley

ADDRESS: Wash

Spec.—1-30—M. & T.—250 Bks

E 59505 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 59505

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2159 Mt. Holly ST. 13-61 WARD)

2-FULL NAME Zenobia Stout

(a) RESIDENCE NO. 2159 Mt. Holly ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel R. Stout

6 DATE OF BIRTH (month, day, and year) Apr 20-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Henry H. Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER ? Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Charles S. Stout

(Address) 2159 Mt. Holly St

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-3-30

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to Aug-3, 1930, that I last saw h[illegible] alive on Aug 2, 1930, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Senile Arteriosclerosis Universal and cerebral, Myocardial degeneration

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Aug 5 1930

20 UNDERTAKER Wm J. Dickenson Sons

ADDRESS N. & Pa

Spec.—12-9-25—A Co.—200 Bks.

E 59506

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59506

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave. Ward 20-2)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Riley

(a) RESIDENCE NO. Home for the Aged M. E. Church. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 0 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm C. Riley

6 DATE OF BIRTH (month, day, and year) July 10, 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Oliver

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England.

12 MAIDEN NAME OF MOTHER Susan Monroe

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Miss Etta Cuddy

(Address) 400 N. Fulton Ave.

Filed AUG 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3, 1930. 19

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1930, to Aug 3, 1930, that I last saw her alive on Aug. 3, 1930, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY Chr. Myocarditis

(Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted ✓

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos. E. Shannon, M. D.

8/4, 1930 (Address) 700 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Aug 6 1930

20 UNDERTAKER Perry Funeral Home ADDRESS North Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59507 ✓

CERTIFICATE OF DEATH

166

E 59507

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes' Hospital St., 20-28 Ward)

2-FULL NAME Ralph C. Doster

(a) RESIDENCE NO. 335 S. Payson St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 1 mos. 23 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10, 1909.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	21	1	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Ship Yard
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER George W. Doster

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rena Cresswell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant George W. Doster
(Address) 335 S. Payson St.

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2- 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide. By taking Corrosive Sublimate —

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke, M. D.

8/3, 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Western Cemetery

DATE OF BURIAL 8/5 1930

20 UNDERTAKER Harry H. Nitzke
ADDRESS 1401 Edmondson Ave

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59508 E 59508

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1933 W. Baltimore ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August J. Murbach

(a) RESIDENCE NO. 1933 W. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha A Murbach

6 DATE OF BIRTH (month, day, and year) Apr. 8, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Mfgr.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Conrad Murbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Elis. Hilzinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Martha Murbach (Address) 1933 W. Balto. St.

15 Filed JUN 5 1930 HARRY [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4-30

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1926, to Aug 4, 1930, that I last saw him alive on Aug 3, 1930, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Sprue all carcinoma of transmitted pulmonary & colon gland

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 27

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Exam

(Signed) Martha A Cox, M. D.

8/5 1930 (Address) 54 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine

DATE OF BURIAL 8/7 1930

20 UNDERTAKER Harry N. Nitzke 4101 Edmondson Ave.

ADDRESS

Spec.—1-30—M. & T.—250 Blks.

E 59509 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59509

CERTIFICATE OF DEATH

1-PLACE OF DEATH Baltimore City Hospt 38

CITY OF BALTIMORE: (No.) Balto. Md (ST.) 10-14 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Peterson

(a) RESIDENCE NO. 1012 Forrest St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Peterson

6 DATE OF BIRTH (month, day, and year) 4/14/1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54		3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer Beth Steel Work

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records Balto City Hospts.

(Address)

15 Filed 8-5-1930 H. HAMPSON MYERS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/3/30

17 I HEREBY CERTIFY, That I attended deceased from 7-31, 1930 to 8-3, 1930

that I last saw him alive on 8-3, 1930

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchio Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebro Spinal Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis? Autopsy pending

(Signed) H. H. Swift M. D.

8-4, 1930 (Address) Baltimore City Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL 8/6/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul st

Spec.—1-30—M. & T.—250 Blks.

2314 E Balto.

E 59510 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59510

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 S. Carlton St. ST., 7th WARD)

2-FULL NAME John Reese Jr.

(a) RESIDENCE NO. 322 S Carlton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Annie.

6 DATE OF BIRTH (month, day, and year) Oct 17 1877

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Box Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Belair Box Co.

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Fordenbaugh.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs. Annie Reese. (Address) 322 S. Carlton

15 AUG 5 - 1930 Filed

H. HASKINS, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Aug. 3, 1930, that I last saw him alive on Aug 3, 1930, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ....yrs. ....mos 3 da.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Eugene L. Pearson, M. D.

8.4.30, 19 (Address) 514 Emory Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul's Cem. DATE OF BURIAL 6th 1930

20 UNDERTAKER H. McCosker 217 St Paul ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 59511

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59511

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2819 Chesterfield Ave ST.. 8-45 WARD)

2-FULL NAME Joan Adele Laird

(a) RESIDENCE NO. 2819 Chesterfield Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Aug 3/30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Clyde Laird

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Clyde Laird
(Address) 3218 Dudley Ave

15 Filed 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Aug 4, 1930, that I last saw h.. alive on Aug 4, 1930, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Tetanus

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Hoacen M. D.

8/4 1930 (Address) 3901 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL 8/5/1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59512

CERTIFICATE OF DEATH.

E 59512 REGISTERED NO. 117

1-PLACE OF DEATH Jewish Hospital. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4-7 ST., WARD)

2-FULL NAME Max Weiner

(a) RESIDENCE NO. Beechville P.O. ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	w	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Weiner.

7 DATE OF BIRTH (month, day, and year) 1876

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchandise (Tea)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

10 NAME OF FATHER Harry Weiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Elizabeth Joffe.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

Informant J. Lewis (Address) 1439 E Balto

Filed 1930 H. [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/4/30.

17 I HEREBY CERTIFY, That I attended deceased from 7/25, 1930, to 8/4, 1930, that I last saw h[illegible] alive on 8/4, 1930, and that death occurred, on the date stated above, at 6.35 P.m.

The CAUSE OF DEATH* was as follows: Apoplexy. Albuminuria & Arteriosclerosis of small vessels.

(duration) yrs. 3 mos da.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 5/15/30 8/4/30

Was there an autopsy? no.

What test confirmed diagnosis? Apoplexy

(Signed) J. T. Ju Andrew, M. D.

, 19 (Address) Jewish Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Rosedale — DATE OF BURIAL 8-5 1930

20 UNDERTAKER J. Lewis, 1439 E Balto — ADDRESS E Balto St

Spec.—1-30—M. & T.—250 Bks.

E 59513

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59513

CERTIFICATE OF DEATH.

194

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 927 E. Balto St., 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Pazanek

(a) RESIDENCE NO. 927 E. Balto. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Frida Pazanek

7 DATE OF BIRTH (month, day, and year) 1842

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

10 NAME OF FATHER Fred Pazanek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Kash—

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Laura

(Address) 1729 E. Balto St.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4-1930

17 I HEREBY CERTIFY, That I attended deceased from July — , 1930, to Aug 4 — , 1930,

that I last saw h— alive on Aug 2 — , 1930

and that death occurred, on the date stated above, at 11 45 A m.

The CAUSE OF DEATH* was as follows:

Senility — Senile Hrt - Cardio - vascular Lupus

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) H.L.d. - Hypostasis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Irvine Bruner, M. D.

, 19 (Address) 125 W Biddle —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Int. Cemetery

DATE OF BURIAL 8-5 1930

20 UNDERTAKER Jack Lewis, 1739

ADDRESS E Balto st

Spec.—1-30—M. & T.—250 Blks.

59514

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59514

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2921 Ridgewood Ave ST., 15-60 WARD)

2-FULL NAME Moses Rull

(a) RESIDENCE NO. 2921 Ridgewood Ave ST., — WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. (mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of: Sarah Rull

7 DATE OF BIRTH (month, day, and year): 1872

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hatter

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Benj. Rull

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rivis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Rivis

(Address): 1439 Eastern Ave

Filed 8-5-1930 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug-4th-1930

17 I HEREBY CERTIFY, That I attended deceased from June-17, 1930, to Aug-4, 1930, that I last saw h... alive on August-4, 1930, and that death occurred, on the date stated above, at 3:15 p. m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio-Renal disease

(duration) about 2-3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none except Lab.

(Signed) Hermann Sindel, M. D.

8/4, 1930 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem., Hebrew Nat. Cem.

DATE OF BURIAL: 8-5 1930

20 UNDERTAKER: Jack Levin, 1731

ADDRESS: E Balto

Spec.—1-30—M. & T.—250 Blks.

59515

E 59515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 2905 Parkwood Ave (STREET) 1359 (WARD)

2-FULL NAME Mary Hollenis

(a) RESIDENCE NO. 2905 Parkwood St. Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	married

6 If married, widowed, or divorced
~~HUSBAND of~~ or) WIFE of Abraham Hollenis

7 DATE OF BIRTH (month, day, and year) Dec. 11, 1887

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	8	4	10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Wolf Handen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Libby Kabe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant (Address) Son, 2905 Parkwood Ave Stanley Hollenis

15 Filed 8-5-1930 C. HAYDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to Aug 4, 1930, that I last saw her alive on Aug 4, 1930, and that death occurred, on the date stated above, at 4 35 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma breast

" Spine

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X rays

(Signed) Raymond E. Lenhard, M. D.

, 19 (Address) 11 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chevy Friendship

DATE OF BURIAL 8-5-1930

20 UNDERTAKER Jack Levine, 1439

ADDRESS E. Balto. St

Spec.—1-30—M. & T.—250 Blks.

E 59516 ✓ E 59516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST., 7-13 WARD)

2-FULL NAME Eva W. Hegeman

(a) RESIDENCE NO. Cheswa Mf ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Samuel Hegeman

7 DATE OF BIRTH (month, day, and year) 1902

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Benj. Dirtsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Helen -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lewis (Address) 1439 E Balto St

15 Filed AUG 5 - 1930 HARRISON JONES, M. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930 to Aug 4, 1930

that I last saw h. alive on Aug 4, 1930

and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Hypernephroma metastases

Pulmonary edema

over

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Hypernephroma, left

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of July 1st 1930

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) Arthur Robert Cohen, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Wash: Road — DATE OF BURIAL 8-5- 1930

20 UNDERTAKER Jose Lewis, 1439 E Balto St — ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

E 59517

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-001 ✓ E 59517

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospital Ward) 7-13

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas E Scheminant

(a) RESIDENCE NO. 1929 E Chase St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 21, 1911

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	19	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist's Helper

(b) General nature of industry, business, or establishment in which employed (or employer) Commercial Pigments

(c) Name of employer Corp. (Curtis Bay)

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

10 NAME OF FATHER Thomas H. Scheminant

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Harley. A & C. Md

12 MAIDEN NAME OF MOTHER Esther Rungquist

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Finland

PARENTS

14 Informant (Address) Mrs Esther Scheminant 1929 E Chase St

Filed 5-1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Motor cycle on which he was riding skidded causing him to be thrown to street

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Rib Multiple Possible Ruptured Lung

(Duration) yrs. mos. ds.

(Signed) C. Hampson Jones M. D.

(Coroner)

8/5, 1930 Address 1931 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Hanover St Bridge

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial Aug 6 1930

20 UNDERTAKER John T Denny ADDRESS 715 Light St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59518

CERTIFICATE OF DEATH.

35

E 59518

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3212 Milford ST., Aug 17 '30 WARD)

2-FULL NAME John Wenger

(a) RESIDENCE NO. 3212 Milford Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 40 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 6, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer) O/O

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Switzerland

10 NAME OF FATHER John A. Wenger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Switzerland

12 MAIDEN NAME OF MOTHER Catherine Maider

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Switzerland

Informant John A. Wenger Jr.
(Address) 3212 Milford Ave.,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1930

17 I HEREBY CERTIFY, That I attended deceased from 7/31 1930 to 8/4 1930

that I last saw him alive on 8/3 1930

and that death occurred, on the date stated above, at 8 or a m.

The CAUSE OF DEATH* was as follows:

Pneumonia - lobar

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cirrhosis, tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? N Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Jno. E. Stacy Jr. M. D.

1930 (Address) 3825 Edmondson Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	8/6/30
UNDERTAKER	ADDRESS
F Vernon Kushner	1532 Hollins St

AUG 5

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66

E 59519

REGISTERED NO. E 59519

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 27-48 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas George Spicer

(a) RESIDENCE NO. 5920 York Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna May Spicer

6 DATE OF BIRTH (month, day, and year) January 18, 1881

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	49	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumbers Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Dr. Hiram L. Spicer

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Scarf

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Annie T. Smith

(Address) 3005 Gwynns Falls Parkway

15 Filed AUG 5 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Alcoholism

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. 1 ds.

(Signed) (Coroner) M. D.

19 (Address) 143 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial Aug. 6 1930

20 UNDERTAKER C. B. Cook ADDRESS 1003 West Baltimore St

Spec.—1-30—M. & T.—250 Blu

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59520

CERTIFICATE OF DEATH.

44 E 59520

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 27-42 WARD)

2-FULL NAME Mrs Charles Buehler (Mary)

(a) RESIDENCE NO. 6240 Belair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Charles Buehler.

7 DATE OF BIRTH (month, day, and year) April 27/1854

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76 years	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Martin Moritz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Louise Schroeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Hospital records

(Address)

15 Filed 1930. C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1930

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1930, to Aug. 4, 1930, that I last saw h alive on Aug 4, 1930, and that death occurred, on the date stated above, at 11:45 m. (Daylight saving)

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach (pylorus)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Anaesthesia & shock.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/4/30.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) R. G. Hills, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Aug 7 1930

20 UNDERTAKER Jos Jacobs & Son

ADDRESS 2178 E. Pratt

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59521 (1-PLACE OF DEATH) — 74-001 — E 59521 (REGISTERED NO.)

CITY OF BALTIMORE: (No.) Provident Hosp. (WARD) 17-24

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sallie Thompson

(a) RESIDENCE NO. 706 Bradley ST., WARD 1
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: John Thomas

6 DATE OF BIRTH (month, day, and year): Dec 1 1886

7 AGE: Years 44 | Months 7 | Days 30 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): N.C.

PARENTS

10 NAME OF FATHER: Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mother

12 MAIDEN NAME OF MOTHER: Mahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Lena Johnson
(Address): 2208 McCulloh

15 Filed 5-1930 192 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): July 31st 1930

I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) Sudden

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ... Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) A. Leslie Hall, M. D. Coroner

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

17 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Aug 5, 1930

UNDERTAKER: Mrs Katie R. Williams

ADDRESS 322 Schroeder St

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59522

CERTIFICATE OF DEATH.

194 E 59522

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 W. Fayette ST. 18 WARD)

2-FULL NAME Mary E. Hartley-Hellyer

(a) RESIDENCE NO. 1204 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 2 mos. 15 da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

If married, widowed, or divorced
HUSBAND of (or) WIFE of Dr. F. W. Hartley-Hellyer

DATE OF BIRTH (month, day, and year) May 17 18[illegible]

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	2	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Andrew Hetz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Klebm

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Dr. F. W. Hartley-Hellyer
(Address) 1204 W. Fayette St.

Filed AUG 5 - 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to ....., 19..., that I last saw h[illegible] alive on Aug 1st, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) ....yrs. ....mos 4 da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 7 yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. T. Lang, M. D.

, 19 (Address) 936 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemy.	Aug. 5 1930
20 UNDERTAKER	ADDRESS
John C. Mitchell & Son 1900	Eutaw Place

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59523

CERTIFICATE OF DEATH

113 E 59523

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 S. Potomac ST., 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eugene Keller

(a) RESIDENCE NO. 14 S Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	—

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) May 4—30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER John Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Pauline Pierunski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John Keller

(Address) 14 S Potomac

15 Filed AUG 5 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Aug 3, 1930

that I last saw him alive on Aug 3, 1930

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Colitis + Intestinal Inflammation

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Colitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M Swanger, M. D.

Aug 5, 1930 (Address) 2612 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Aug 5 1930

DATE OF BURIAL

20 UNDERTAKER H M Rozewski 1930

ADDRESS Eastern Ave

Spec.—1-30—M. & T.—250 Bks.

Borowy. ✓

295-20

E 59524

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002 E 59524

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2-4 ST., 2 WARD)

2-FULL NAME Charles Borowy

(a) RESIDENCE No. 1612 Shakespeare ST., 2d WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) July-10-1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md —

10 NAME OF FATHER Charles Borowy

11 BIRTHPLACE OF FATHER (city or town) Mass (State or country)

12 MAIDEN NAME OF MOTHER Lama Klesid

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

Filed 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1930, to Aug 4, 1930, that I last saw him alive on Aug 4, 1930, and that death occurred, on the date stated above, at 5-5-0 P m.

The CAUSE OF DEATH* was as follows:

Toxic Dysentery, bacillary

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R.O.Y. Warren, M. D.

, 19 (Address) Wolfe 5500

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Aug 6

DATE OF BURIAL 1930

20 UNDERTAKER J. Rozanski

ADDRESS 1930 Eastern

Spec.—8-16-29—L. F. S.—100 Blks.

E 59525

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59525

CERTIFICATE OF DEATH

101-001

REGISTERED NO.

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. 811 N. Modena ST., 7-12 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Centon Marsalek

(a) RESIDENCE NO. 811 N. Modena ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) Aug 16 12

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	17	11	15 17	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Henry Marsalek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Elizabeth Linke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

Informant Henry Marsalek
(Address) 811 N. Modena St

Filed Aug 5 1930 C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3/30

17 I HEREBY CERTIFY, That I attended deceased from July 28 30 to Aug 3 1930
that I last saw h... alive on Aug 2 1930
and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) 7 yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Cardiac Dilatation
(duration) rs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Findings
(Signed) Fred Duffy M. D.
1930 Address 800 N Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Aug 6 1930

ADDRESS

20 UNDERTAKER Gent Funeral Co 1916 Baltimore

pec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 59526

E 59526

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 W. Hamburg ST., 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henretta Johnson

(a) RESIDENCE NO. 206 W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	Col	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Johnson (?)

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 44			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) (

(c) Name of employer

BIRTHPLACE (city or town) Calvert Co. (State or country) Md.

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. (State or country) Md

12 MAIDEN NAME OF MOTHER Cora Johnson

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co (State or country) Md.

Informant Bertha Brown

(Address) 931 Leadenhall St

Filed 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 1930

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1930, to Aug 3, 1930, that I last saw h. alive on Aug 2, 1930 and that death occurred, on the date stated above, at 12.57 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? (

Did an operation precede death? (Date of (

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) O. Tarsell, M. D.

, 19 (Address) 830 Hamp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. John's Calvert Co Md

DATE OF BURIAL aug 6 1930

ADDRESS

20 UNDERTAKER

108 W. Monte S L Brown & Son

pec.—1-30—M. & T.—250 Blks.

E 59527 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59527

38

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital Street or Avenue

2-FULL NAME Martha McCoy

(a) RESIDENCE NO. 449 Little Monument 11-24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	married

6 If married, widowed, or divorced HUSBAND of or) WIFE of ✓

DATE OF BIRTH (month, day, and year) 1859

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71				

OCCUPATION OF DECEASED Cook

(a) Trade, profession or particular kind of work 21

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

BIRTHPLACE (city or town) Washington D C.
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Informant
(Address) UNIVERSITY OF MARYLAND

Filed Aug 5 1930 C. HAMPSON JONES, M. D. Commissioner Health.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1930, to July 28, 1930, that I last saw her alive on July 28, 1930, and that death occurred, on the date stated above, at 12 45 A. m.

The CAUSE OF DEATH* was as follows:

Luetic aortic vascular disease

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy and Clinical signs and symptoms

(Signed) George H. Yeager M. D.

8/1, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL AUG 5 - 1930 19

20 UNDERTAKER

ADDRESS

Spec.—1-12-23—M&T—500 Bks.

E 59528 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 59528

CERTIFICATE OF DEATH. 101-001

REGISTERED NO.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. West Baltimore General Hospital ST., WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Morris Shecter

(a) RESIDENCE NO. 4117 Forest Park Ave ST., 15 WARD 6th
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 22/08

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	21 22	11	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS
10 NAME OF FATHER Samuel
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Lena
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) S. Shecter 4117 Forrest Pk Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5 1930

17 I HEREBY CERTIFY, That I attended deceased from August 3, 1930, to August 5, 1930, that I last saw him alive on August 5, 1930, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia
(duration) ..... yrs. ..... mos 2½ ds.

CONTRIBUTORY (Secondary) Cardiac dilatation over
(duration) ..... yrs. ..... mos. over ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) H. Lehmann, M. D.
, 19 (Address) W. Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Windsor Hill Rd — DATE OF BURIAL Aug 5 1930

20 UNDERTAKER Jack Lewis — ADDRESS 1431 E Balto St

Spec.—1-30—M. & T.—250 Blks.

E 59529

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59529

CERTIFICATE OF DEATH.

28.64 89

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3911 Maine Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham H. Summerfield

(a) RESIDENCE NO. 3911 Maine Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced (HUSBAND) of (or) WIFE of Jennie Mann Summerfield

DATE OF BIRTH (month, day, and year) Jany. 19, 1876

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	6	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Woolen

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

BIRTHPLACE (city or town) Philadelphia,

(State or country) Pa.

10 NAME OF FATHER Myer Summerfield

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Carrie Bowers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

Informant Mrs. Jennie M. Summerfield

(Address) 3911 Maine Ave.

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3rd. 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1924 to Aug. 3, 1930, that I last saw h[illegible] alive on Aug. 3, 1930, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore H. Monnson M. D.

, 19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 8/6/ 1930

20 UNDERTAKER David Sondheimer Son

ADDRESS 1902 Eutaw Place

sec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59530

CERTIFICATE OF DEATH

X 179 E 59530

REGISTERED NO.

1—PLACE OF DEATH Maryland General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Madison-Linden ST. 11-24 WARD)

2—FULL NAME Mr. Booker Goode

(a) RESIDENCE NO. 827 No. Side Sparrows PLACE ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

If married, widowed, or divorced (or) WIFE of Mrs Anabelle Goode

DATE OF BIRTH (month, day, and year) 1884

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Steel

(c) Name of employer Bethlehem Steel Corp

BIRTHPLACE (city or town) (State or country) Farmsville Va

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Anna Bell Good

(Address) Farmsville Va

File 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3, 1930.

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1930 to August 3, 1930

that I last saw h[illegible] alive on August 3, 1930

and that death occurred, on the date stated above, at 7 15 P.m.

The CAUSE OF DEATH* was as follows:

1. 3rd degree burn (Burn)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted (burn) if not at place of death? at works

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John W. Clements, M. D.

, 19 (Address) Maryland Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Farmsville Va

DATE OF BURIAL Aug 5th 1930

20 UNDERTAKER S. L. Brown's Son

ADDRESS 108 W. Monty St

Dec.—1-30—M. & T.—250 Bks.

39422
E 59531

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59531

CERTIFICATE OF DEATH.

REGISTERED NO. 139

1-PLACE OF DEATH Johns Hopkins Hospital ST., 26 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Louise Rivelli

(a) RESIDENCE NO. 6124 Eversall Ave., ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of August Rivelli

DATE OF BIRTH (month, day, and year) Apr. 24, 1896

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	3	12 10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Mass.

10 NAME OF FATHER Levi Pasone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Lena Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

Informant Johns Hopkins Hospital Records (Address)

Filed 1930 By HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to August 4, 1930, that I last saw her alive on August 4, 1930, and that death occurred, on the date stated above, at 4 20 m.

The CAUSE OF DEATH* was as follows:

Myocardial failure Rheumatic heart disease

(duration) ? yrs. ? mos ? ds.

CONTRIBUTORY (Secondary) Operation for Myoma uteri. (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Aug. 31, 1929

Was there an autopsy? yes

What test confirmed diagnosis? ~~yes~~ Autopsy

(Signed) H. S. Everett, M. D.

8/5, 1930 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

20 UNDERTAKER Jos. Lahrens

DATE OF BURIAL 8/7/30

ADDRESS 221 Bway

...per.—2-29-28—L. P. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59532 ✓ 129 E 59532

REGISTERED NO.

E 59532

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 N. Hashington ST., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence Edward Mulligan

(a) RESIDENCE NO. 2012 N. Hashington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Eva G. Mulligan

DATE OF BIRTH (month, day, and year) Aug 12 - 1893.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	36	11	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Contractor 886

(b) General nature of industry, business, or establishment in which employed (or employer) Heater Roofing

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER John F. Mulligan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Emma Heise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Emily Bright (Sister)

(Address) 537 E 28

1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5-1930

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1930, to aug 5, 1930,

that I last saw him alive on aug 4, 1930

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation (Decompensated)

Uraemia 5 days

(duration) yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 1 mos. 17 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uraemia

(Signed) Thos. F. Stevens, M. D.

8/5, 1930 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Holy Rosary Cem Aug 7 1930

ADDRESS

20 UNDERTAKER John M. Veldrew 401 E Chester St

Spec.—1-30—M. & T.—250 Blks

(Later) Birth Cer. shows Born alive at 7.20 A.M. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59533

CERTIFICATE OF DEATH.

161-001 E 59533

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3455 Ash ST., 13-52 WARD)

2-FULL NAME Boy Baby Slater

(a) RESIDENCE NO. 3455 Ash ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 1 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) .....
(State or country) Md.

10 NAME OF FATHER Chas. Emory Slater

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Baltimore County

12 MAIDEN NAME OF MOTHER Emma Clotfelter Miller

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Baltimore, Md

Informant .....
(Address) C. HAMPSON JONES, M.D.

Filed Aug 5 - 1930 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930, to Aug 4, 1930,
that I last saw him alive on Aug 4, 1930,
and that death occurred, on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:

Still Birth

(duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Still Birth

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. H. Davis M.D.

, 19 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	Aug 6 1930
20 UNDERTAKER Chesnutwood	ADDRESS 3615 Chestnut Ave

pec.—1-30—M. & T.—250 Bks

E 59534

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59534

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 13-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Nolt

(a) RESIDENCE NO. 1101 W 37th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa A. Nolt.

7 DATE OF BIRTH (month, day, and year) April 2 1852

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78.	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Louisa A. Nolt

(Address) 1101 W 37th St.

Filed 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5/30

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1930, to Aug 5, 1930, that I last saw h... alive on 8-5, 1930, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Prostate ?

(duration) ....yrs. ? mos ....ds.

CONTRIBUTORY (Secondary) —

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes Clinical & autopsy

What test confirmed diagnosis?

(Signed) J Leyho, M. D.

8/5, 1930 (Address) J Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Aug 8. 1930

20 UNDERTAKER Thomas Lee

ADDRESS 3615 Chestnut ave

Spec.—1-30—M. & T.—250 Bks.

John B. Suit ✓

239498
med.
E 59535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 E 59535

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. 27-48 WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME John B. Suit

(a) RESIDENCE NO. 806 Beaumont Ave, St. Govans WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 6, 1858.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	7	29	
72				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Benj Suit

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emmie S Sechels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 1930 G. HALL JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5, 1930.

17 I HEREBY CERTIFY, That I attended deceased from August 2, 1930, to August 5, 1930, that I last saw him alive on August 5, 1930, and that death occurred, on the date stated above, at 10:05 P.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ....yrs. ....mos 9 ds.

CONTRIBUTORY (Secondary) None (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray of chest

(Signed) James Bordley III, M. D.

8/5, 1930 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md — DATE OF BURIAL Aug 6th 1930

20 UNDERTAKER Jas T. Sayler Sons — ADDRESS Annapolis Md.

Rec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 59536

REGISTERED NO. 59536

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital WARD) 14 Y0 X

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret L. Schaub

(a) RESIDENCE NO. 5 ST. Roquel ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Catonsville md yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced HUSBAND of (or) WIFE of Harry J. Schaub.

DATE OF BIRTH (month, day, and year) Nov. 9, 1885

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	8	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

BIRTHPLACE (city or town) Baltimore Co. (State or country) Maryland.

10 NAME OF FATHER Perrenn Doyle

11 BIRTHPLACE OF FATHER (city or town) Ireland. (State or country)

12 MAIDEN NAME OF MOTHER Katherine Dailey

13 BIRTHPLACE OF MOTHER (city or town) Ireland. (State or country)

Informant Harry J. Schaub.

(Address) 5 Roquel ave - Catonsville Md.

Filed 1930. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930, to Aug 5, 1930

that I last saw her alive on Aug 5, 1930

and that death occurred, on the date stated above, at 6 20 P m. (D.S.T.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio-vascular-renal disease.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) Rudolph L. Schorke M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 8/8 1930

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light St.

pec.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 59537

REGISTERED NO. 59537

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1531 E. 33rd ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Bath

(a) RESIDENCE NO. 1531 E. 33rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 11 mos. 1 da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie R. Bath

DATE OF BIRTH (month, day, and year) 9-1871

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	11	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Standard Oil

(c) Name of employer City

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER John Bath

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.J.

12 MAIDEN NAME OF MOTHER Pauline Strauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mamie Bath (Address) 1531 E. 33rd St

Filed 1930 C. H. [illegible] JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to Aug. 4, 1930, that I last saw him alive on Aug 4, 1930, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos 4 da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 6 yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. T. Cunningham M. D.

(Address) 2858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Com

DATE OF BURIAL Aug 7, 1930

20 UNDERTAKER H. E. Richardson

ADDRESS Aug-7/30

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59538

CERTIFICATE OF DEATH.

113 E 59538

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2675 Pennsylvania Ave. St., 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Cecelia Malone

(a) Residence No. 2675 Pennsylvania Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct. 21, 1929

7-AGE, 0 yrs. 9 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, Wm A. Malone

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto, Md

12-MAIDEN NAME OF MOTHER, Edith M. Knox

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Tampstown Md

14- (Informant) Wm A. Malone

(Address) 2675 Penna Ave.

15-

Filed 1930 C. HAYDEN JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 5, 1930

17- I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to Aug 5, 1930, that I last saw h[illegible] alive on Aug 5, 1930, and that death occurred, on the date stated above, at 3 00 a. m.

The CAUSE OF DEATH* was as follows:

Entero-colitis

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual tests

(Signed) George A. Knipp, M. D.

, 19 (Address) 3030 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL, Aug 7, 1930

20-UNDERTAKER. Wm J Tickner & Son

ADDRESS North & Pa

Dec.—1-30—M. & T.—250 Blks

Jessie Widerman

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 59539

REGISTERED NO.

59539

1-PLACE OF DEATH Mercy Hospital ST., 4-7 WARD X

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Jessie Widerman

(a) RESIDENCE NO. Owings Mills, Md. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of F

DATE OF BIRTH (month, day, and year) Nov 13 1874

AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	55	8	24	

OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Attendant at Rosemary Training School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Thos Arthur Widerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annabelle Boyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Hospital Records

(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5-30

17 I HEREBY CERTIFY, That I attended deceased from 7-11, 1930, to 8-5, 1930, that I last saw him alive on 8-5, 1930, and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma head of pancreas

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Arteriosclerotic CV disease

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 29 '30

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Operation

(Signed) J. Leyko, M. D.

8-5, 1930 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Aug 6 1930

20 UNDERTAKER Chas E. Israel

ADDRESS 802 Madison Ave

Filed 1930 C. HAMPSON JONES, M. D.

Registrar

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59540 — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 59540 — DEATH

1 PLACE OF DEATH

City of Baltimore: (No.) Mercy Hospital St., 20-69 Ward) 194

2 FULL NAME John J. Kelly

(a) RESIDENCE NO. 2145 West Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of Myrtie M. Beasley Kelly

6 DATE OF BIRTH (month, day, and year) April 30, 1897

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	33	3	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Bartlett & Hayward Co

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas J. Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Annie Mannion

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant (Address) Mrs Myrtie M. Kelly 2145 West Fayette St.

15 Filed AUG 6 1930 H. [illegible] JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 Aug 4, 1930.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation (Strangulation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Suicide

(duration) yrs. mos. ds.

18 Where was disease contracted? —
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Aug 5, 1930 (Address) 1639 Gundry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. — DATE OF BURIAL: 8/7/1930

20 UNDERTAKER: John J. Cowan & Louis Hollins Sr. — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 59541

REGISTERED NO. E 59541

E 59541
1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1212 Ellis ST., 17 WARD)

2-FULL NAME Lilly Truett

(a) RESIDENCE NO. 1212 Ellis
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

, ST., WARD
(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Truett

6 DATE OF BIRTH (month, day, and year) July 31st 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at Home
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS
10 NAME OF FATHER Wm Chase
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto
12 MAIDEN NAME OF MOTHER Bessie Shanks
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Samuel Truett 1212 Ellis St

15 Filed 8-5-1930 C. "HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 31st 1930, to Aug 4th 1930, that I last saw her alive on Aug 4th 1930, and that death occurred, on the date stated above, at 7.00 a. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia post

(duration) yrs. , mos 4 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Aug 3/30
Was there an autopsy? No.
What test confirmed diagnosis? Clinical.

(Signed) Geo. H. Lauenbach, M.D.
(Address) 2215 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Aug 7 1930

20 UNDERTAKER John H. Trader — ADDRESS 1037 Druid Hill

pec.—1-12-23—M&T—500 Bks.

59542

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 59542

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 409 N. Gilmor ST. (WARD) 14-2

2-FULL NAME Charles Edward Dixon

(a) RESIDENCE NO. (Usual place of abode) 409 N. Gilmor ST. WARD

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Estella Emma Dixon 1887

DATE OF BIRTH (month, day, and year) Sept. 10, 1887

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	42	11	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Rigger

(b) General nature of industry, business, or establishment in which employed (or employer) Iron worker

(c) Name of employer Beth. Steel Co.

BIRTHPLACE (city or town) (State or country) Rochester Co. Md.

10 NAME OF FATHER John Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rochester Co. Md.

12 MAIDEN NAME OF MOTHER Rosie Mary Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Roche sterCo. Md.

14 Informant (Address) Pansie Dixon 409 N. Gilmor St.

15 Filed 8-1930 (19) H. [illegible] K. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5 1930

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1930, to Aug. 5, 1930, that I last saw h[im] alive on Aug. 5, 1930, and that death occurred, on the date stated above, at 1:50 a.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Right Side

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At place odf death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL Aug 8 1930

20 UNDERTAKER John H Goodwin

ADDRESS 1027 Hanover

pec.—1-30—M. & T.—250 Bks.

E 59543

59543

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ..... ST. 36 37 WARD 44

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gust Salovaris

(a) RESIDENCE NO. 4515 Eastern Ave. ST., ... WARD Greece
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Salovaris

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60				

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory Work

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Greece

10 NAME OF FATHER John Salovaris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Irene ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

Informant Records of
(Address) Baltimore City Hospitals

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

AUG 6 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5/30

17 I HEREBY CERTIFY, That I attended deceased from 7/7/30, 19..., to 8/5/30, 19..., that I last saw him alive on 8/5/30, 19..., and that death occurred, on the date stated above, at 12.05 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus
with metastasis to liver

(duration) unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ....yrs. ....mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Fred M. Dukeman, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

UNDERTAKER Lilly & Zeiler Inc

DATE OF BURIAL Aug. 7th 1930

ADDRESS 403 N Wolfe St

59544

59544 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 N. Decker ave ST., 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances B. Kreppel

(a) RESIDENCE NO. 709 N. Decker ave ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Nov. 14th 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Frederick G. Kreppel

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Frances Sollers

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Frederick G. Kreppel

(Address) 709 N. Decker ave

15 Filed 8-1930 C. H. WILLIAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1930, to Aug. 5, 1930, that I last saw her alive on Aug. 4, 1930, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Pertussis — Acute bronchitis

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. data

(Signed) Jos. Schlenger, M. D.

. 19 (Address) 3034 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL Aug. 6th 1930

20 UNDERTAKER P. Kelly + Son

ADDRESS 4030 E. Monument St

...ec.—1-30—M. & T.—250 Blks

E 59545

✓ E 59545

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (NO.....ST., 16 WARD

2-FULL NAME John Kelly

(a) RESIDENCE NO. 703 S. Caroline st. ST., ... WARD 2-J

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Annie

DATE OF BIRTH (month, day, and year) Aug. 29, 1879

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50	51	11.	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Jeremiah Kelly

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Nora Conway

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

Informant Hospital Records

(Address)

Filed AUG 6 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to Aug. 4, 1930, that I last saw him alive on Aug. 4, 1930, and that death occurred, on the date stated above, at 1.55 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of esophagus

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) David Seuss, M. D.

8-4, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL Aug. 7th 1930

20 UNDERTAKER Kelly & Julian Inc.

ADDRESS 403 S. Arlington Ave

Dec.—1-30—M. & T.—250 Bks.

R 39501
Ped E 59546

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32

E 59546
REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 10-14 ST., WARD)

2-FULL NAME Marian Harris

(a) RESIDENCE NO. 1117 Mc Donough ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Nov. 14, 1928

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	20	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Marion Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Marian Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 1930 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5-1930.

17 I HEREBY CERTIFY, That I attended deceased from 8-2, 1930, to 8-5-30, 19....,

that I last saw h[illegible] alive on 8-5-30, 19....,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

tbc meningitis.

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Mesenteral tbc. (duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1117 Mc Donough St.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) [illegible] M. D.

8-[illegible]-19... (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cushylemty

DATE OF BURIAL Aug 6 1930

ADDRESS 1725 Eastlendon

UNDERTAKER Mrs. P. G. Elbert

Rec.—8-16-29—L. F. S.—100 Bks. Mary G. Shearer ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59547

CERTIFICATE OF DEATH

129 E 59547

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 Edgewood ST. 20.69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary G. Shearer

(a) RESIDENCE NO. 422 Edgewood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Wm C. Shearer

DATE OF BIRTH (month, day, and year) Nov. 5 1870

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	8	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Carroll County Maryland.

10 NAME OF FATHER Wm H Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Mary N Myers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

Informant Wm C. Shearer

(Address) 422 Edgewood St.

Filed [illegible] 19 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4-1930.

17 I HEREBY CERTIFY, That I attended deceased from June 25- 1930, to August 4 1930, that I last saw her alive on August 4 1930, and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(duration) unknown. yrs. mos. ds.,

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis + physical signs

(Signed) Chester Rieland, M. D.

8-5-, 1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Manchester Cemetery Carroll Co Md.	Aug. 6 1930
UNDERTAKER	ADDRESS
H. L. H. Bergman	Manchester Md.

ec.—1-30—M. & T.—250 Blks

E 59548 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59548

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. ST. WARD)

2-FULL NAME Anna Connelly

(a) RESIDENCE NO. 1823 Maryland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of unknown.

DATE OF BIRTH (month, day, and year) unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50?; 65?	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 69

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant (Address) Records of BALTIMORE CITY HOSPITALS

Filed 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1925, to Aug. 5, 1930, that I last saw h[illegible] alive on Aug 5, 1930, and that death occurred, on the date stated above, at 6:55 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 1. House. 2. Hospital

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget M. D.

8-5, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 8/7/1930

20 UNDERTAKER Wm Cook

ADDRESS 1219 St Paul St

dec.—1-30—M. & T.—250 Bks

E 59549 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 E 59549

CERTIFICATE OF DEATH. REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hosp. ST. 2-49X WARD (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Miss Anna E. Happ.

(a) RESIDENCE NO. 722 Walnut Ave. — Trenton N.J. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) April 16, 1886.

AGE Years	Months	Days	If LESS than 1 day....hrs. or....min.
44	3	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porcelain Work.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Albany, N.Y.

10 NAME OF FATHER John Louis Happ.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Burst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

Informant Brother

(Address) 722 Walnut St. Trenton N.J.

Filed AUG 6 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5, 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to Aug 5, 1930, that I last saw h.. alive on Aug 5, 1930, and that death occurred, on the date stated above, at 7.35 P m D.S.T.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Post Operative

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 31, 1930.

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Michael J. Crawford M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenwood Cemetery Trenton New Jersey

DATE OF BURIAL 8/7/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

JONES, M. D. Registrar

ec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59550

CERTIFICATE OF DEATH.

129

E 59550

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No.) 637 Wyeth ST. 21 WARD 29

2-FULL NAME Cora M. Howard

(a) RESIDENCE NO. 637 Wyeth ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of Single

DATE OF BIRTH (month, day, and year) Sept 3rd 1897

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
32	11	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Wm T. Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co.

12 MAIDEN NAME OF MOTHER Ida V. Nash

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto Md

Informant Wm T. Howard

(Address) 637 Wyeth St

Filed ..., 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1930, to Aug 4, 1930

that I last saw h— alive on Aug 3, 1930

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Chronic

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Usual

(Signed) [signature], M. D.

[illegible], 193[illegible] (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 8/7/1930

20 UNDERTAKER Wm Cook 1217

ADDRESS St Paul St

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59551 ✓

CERTIFICATE OF DEATH

E 59551

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St., 11 ~~st~~ Ward) 66

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Pansatton

(a) RESIDENCE NO. 1103 Play St. St., Ward 1103 Play St

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Div.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Saint Dresser
(b) General nature of industry, business, or establishment in which employed (or employer) Hosp
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER G. Pansatton

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER C. Cavaday

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mary Pansatton
(Address) 1103 Play St

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 - 32

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Dilat Heart (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. J. Rhein, M. D.

July 6, 1932 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 8/6 1932

20 UNDERTAKER W. P. Cook

ADDRESS 1217 E Fayette St

Spec.—1-10-21—M&T—1500 Bks.

59552

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

111 E 59552

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 Patapsco Ave ST., 2 WARD) Brooklyn 7

2-FULL NAME Nora Anderson

(a) RESIDENCE NO. 422 Patapsco Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE Wh | 5 Single, Married, Widowed, or Divorced, (write the word) Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 12th 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	2	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Clinton Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Edna M Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo C Anderson (Address) 422 Patapsco St

15 Filed 6 1930 C. RAMSAY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5th 1930

17 I HEREBY CERTIFY That I attended deceased from Aug 4 1930 to Aug 5 1930

that I last saw her alive on Aug 4 1930

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Colitis, Acute.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of —

Was there an autopsy? No Exam.

What test confirmed diagnosis?

(Signed) R W Johnson, M. D.

, 19 (Address) 3564 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 8/7/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

Sec.—1-30—M. & T.—250 Blks.

Hester Robinson ✓

59553

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 59553

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 804 Calhoun ST. 16 WARD)

2-FULL NAME Hester Robinson

(a) RESIDENCE NO. 804 Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of or) WIFE of: John Robinson

DATE OF BIRTH (month, day, and year): 1869—

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer: Unknown

BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Mrs. J. Edward (Address) 804 Calhoun St

Filed: Aug 6 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/4/30

17 I HEREBY CERTIFY, That I attended deceased from 8/1/30 19..., to 8/4/30 19..., that I last saw h... alive on 8/4/30 3:00 P.M. and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Pulmonary Metast

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. L. Hess, M. D.

8/6, 1930 (Address) 924 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Aug 6 1930

UNDERTAKER: Virginia A. Brooks

ADDRESS: 1623 E. Lanvale St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59554

CERTIFICATE OF DEATH

E 59554

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 614 Conway St. 22-30 Ward)

2-FULL NAME Arthur King

(a) RESIDENCE NO. 614 Conway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Negro	Single

5a If married, widowed or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	25			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) S.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Rosa Knox
(Address) 614 Conway

15 Filed 8-6-1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage due to pistol-shot of left lung. Homicide.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene Feller, M. D.

8/6, 1930. (Address) 1739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenwood SC	Aug 7 1930
UNDERTAKER	ADDRESS
Joseph A Lively	409 N Mount St

8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59555

CERTIFICATE OF DEATH

111-002 E 59555

1—PLACE OF DEATH

REGISTERED NO. 16-69

CITY OF BALTIMORE: (No. 2542 Edmondson Ave. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Berardino Frank Paterra

(a) RESIDENCE NO. 2542 Edmondson Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Lenata Paterra

6 DATE OF BIRTH (month, day, and year) Sept-16-1869.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	10	20	19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer) Confectioning 045

(c) Name of employer Self

9 BIRTHPLACE (city or town) Naples (State or country) Italy.

10 NAME OF FATHER Gaetano Paterra

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Italy.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

Informant Lenata Paterra

(Address) 2542 Edmondson Ave

Filed [illegible] 1930 C. H. [illegible] JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5-1930.

17 I HEREBY CERTIFY, That I attended deceased from August 2, 1930, to August 5, 1930, that I last saw him alive on August 5, 1930 and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Duodenal Ulcer (perforated)

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical Signs & Symptoms

(Signed) Chester Riland, M. D.

8.6. 1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 8/8/30

20 UNDERTAKER George J. Pfeltz Son

ADDRESS 1235 Hanover

12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59556 — CERTIFICATE OF DEATH. — 155 — E 59556

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1733 N Caroline ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Manning

(a) RESIDENCE NO. 1733 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced HUSBAND of (or) WIFE of: James Manning

DATE OF BIRTH (month, day, and year): 9/20/1860

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Ireland

10 NAME OF FATHER: James Sully

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Donavan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

Informant: James Manning

(Address) 1733 N Caroline St

Filed ... 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1930, to Aug. 5, 1930, that I last saw her alive on Aug 5, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

"Regets" Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Myocardial Insuff

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Benj. D. Hayden, M. D.

, 19 (Address) 1216 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: 8/8 1930

UNDERTAKER: George J Ruth Inc

ADDRESS: 1935 Harford

...c.—1-30—M. & T.—250 Blks

59557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

56

E 59557

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 27.4th WARD)

2-FULL NAME Phillip Stark Poeder

(a) RESIDENCE NO. 2709 Westfield Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	S

If married, widowed, or divorced HUSBAND of (or) WIFE of .....

DATE OF BIRTH (month, day, and year) Feb 11 - 1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	5½	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) Ba Md

(State or country)

10 NAME OF FATHER Herman Poeder

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margarete Stark

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Germany

Informant Mrs Poeder

(Address) .....

Filed ..... 8 - 1930 H. Klutz JONES M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5-30

17 I HEREBY CERTIFY, That I attended deceased from 8-3, 1930, to 8-5, 1930, that I last saw h alive on 8-6, 1930, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Tetany

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Rickets

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Feyko, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem.

DATE OF BURIAL 8/7/30

20 UNDERTAKER George D. Duff & Son

ADDRESS 1735 Harford

...—1-30—M. & T.—250 Blks

E 59558

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

REGISTERED NO. E 59558

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 27-44 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Brennis

(a) RESIDENCE NO. 327 N Patapsco Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) April 10 1866

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	3	26	X

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country)

10 NAME OF FATHER Phillip Brennis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Bormuth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Hospital Records

(Address)

Filed ..., 19 ... Registrar

C. HARRY JONES, M. D.

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5-30

17

I HEREBY CERTIFY, That I attended deceased from 7-16, 1930, to 8-5, 1930,

that I last saw her alive on 8-5, 1930,

and that death occurred, on the date stated above, at 8-20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Sigmoid Colon

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis C V disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 8-1-30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical - Operation - Autopsy

(Signed) J Fuchs, M. D.

8/5, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 8/8/30

20 UNDERTAKER George J Potts Inc

ADDRESS 1735 Harford Ave

E 59559 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59559

CERTIFICATE OF DEATH

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp (WARD) 22.30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dail Harris

(a) RESIDENCE NO 106 Perry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day and year) Dec 26-1929

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Edgar Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Louisa Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Louis Harris

(Address) 106 Perry St

15 Filed AUG 6 - 1930

C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) .... yrs. .... mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Smith, M. D. Coroner

Aug 4 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 8/6/1930

UNDERTAKER Mrs Geo. H. Holland

ADDRESS 1632 Dan

c.—1-30—M. & T.—250 Bks.

E 59560

E 59560

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

137

REGISTERED NO. 11-24

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University of Md ST., Hospital WARD

2-FULL NAME Miss Helen Dunn

(a) RESIDENCE NO. 1214 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) July 14/1894

6 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36		21 22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto Ear Eye & Throat Hospital

BIRTHPLACE (city or town) (State or country) Hagerstown Md

10 NAME OF FATHER Edwin C Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hagerstown Md

12 MAIDEN NAME OF MOTHER Alice V Swartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hagerstown Md

Informant Dr Maxwell S Dunn

(Address) 245 Melrick Rd Rockville Centre Long Island

Filed 1930 C. H. [illegible] JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5-30

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to Aug. 5, 1930, that I last saw h.e alive on Aug. 5, 1930, and that death occurred, on the date stated above, at 2:25 P.m.,

The CAUSE OF DEATH* was as follows:

Chocolate Cyst right ovary

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Intestinal obstruction (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 7-29-30 8-5-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) Henry J Harris, M. D.

, 19 (Address) Hagerstown Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rose Hill Cemetery Hagerstown Md	Aug 7 1930
20 UNDERTAKER Dr Harry H Armacost	ADDRESS 4204 Ridgewood Ave

...—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59561

CERTIFICATE OF DEATH.

49 E 59561

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2032 Wilkens ave ST., 20-28 WARD)

2-FULL NAME Annie Zimmerman

(a) RESIDENCE NO. 2031 Wilkens Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 9, 1851

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	10	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER William Oldham

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Susanna Freeman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

Informant Mrs Lillie M Crowley

(Address) 2031 Wilkens Ave

Filed AUG 8 - 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5 1930

17 I HEREBY CERTIFY, That I attended deceased from 10/5, 1929, to 8/5, 1930,

that I last saw her alive on 8/5, 1930,

and that death occurred, on the date stated above, at 4:35 P. m.

The CAUSE OF DEATH* was as follows:

Glioma of cerebrum

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) 2030 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet

DATE OF BURIAL: Aug 9 1930

20 UNDERTAKER: J Vernon Kechner

ADDRESS: 532 E Hollins

c.—1-30—M. & T.—250 Bks.

E 59562

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59562

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) University Hospital ST., 20-69 WARD

2-FULL NAME Carolyn Schmidt

(a) RESIDENCE NO. 2136 Lehman St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) March 7, 1890

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	40	4	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Adolf Broadway (Address) 2136 W. Mount St

Filed 1029 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 30

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1930, to Aug 4th, 1930, that I last saw her alive on Aug 4th, 1930, and that death occurred, on the date stated above, at 10 o'clock P.m.

The CAUSE OF DEATH* was as follows:

Generalized Carcinomatosis with the primary growth in left adrenal gland.

(duration) 4 mos. 5 ds.

CONTRIBUTORY None (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic Examination

(Signed) See Pages, M. D.

Aug 6, 1930 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Aug 7 1930

ADDRESS 532 Hollins

20 UNDERTAKER Vernon Kelhower

Rec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

59563 — REGISTERED NO. 129 — E 59563

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) St Joseph Hospital (ST.) 11-15 (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Carter

(a) RESIDENCE NO. Mt. Royal Hotel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of Single

DATE OF BIRTH (month, day, and year) January-10-1859

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71	70	6	24	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Office
(c) Name of employer United Railways Baltimore

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER A Robert Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Anne Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila. Penna.

Informant Dr. J. Carey Parran
(Address) Mt Royal Hotel

Filed ..... 19 ..... J. H. BLAKE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-4-30

17 I HEREBY CERTIFY, That I attended deceased from 7-27, 1930, to 8-4, 1930, that I last saw h[illegible] alive on 8-4, 1930, and that death occurred, on the date stated above, at 1:35 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis with Uraemia
(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home.
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings.

(Signed) W. B. Tinsley M. D.
, 19 (Address) 14 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery
DATE OF BURIAL August 1/30

20 UNDERTAKER [illegible] & MOWEN COMPANY
(WILLIAM F. [illegible])
ADDRESS 108 W. NORTH AVE.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59564

CERTIFICATE OF DEATH

194 E 59564

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 501 S Pulaski St., 70-76 (Ward)

2-FULL NAME Minacha Goodman

(a) RESIDENCE NO. 501 S. Pulaski St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Goodman

6 DATE OF BIRTH (month, day and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Hans Goodman
(Address) 501 S Pulaski St

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to L death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Heart

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas B Moore, M. D.

8-6-1930 (Address) Brooklyn Md

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL 8-7 1930

20 UNDERTAKER Jack Levine

ADDRESS 1439 Bank St

1930 R. P. JONES, M.D.

c.—1-30—M. & T.—250 Bks.

59565

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59565

CERTIFICATE OF DEATH.

REGISTERED NO. 16.23 44

1-PLACE OF DEATH Baltimore City Hospital

TY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bryan

(a) RESIDENCE NO. 718 N Arlington Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
[illegible]	colored	married.

If married, widowed, or divorced HUSBAND of (or) WIFE of unknown.

DATE OF BIRTH (month, day, and year) 1864

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic.

(b) General nature of industry, business, or establishment in which employed (or employer) ? 10

(c) Name of employer ?

BIRTHPLACE (city or town) Baltimore

(State or country) Md.

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) ?

12 MAIDEN NAME OF MOTHER Susan Jackson

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Md.

Informant Rumsey Bryan

(Address) Baltimore City Hosp.

Filed [illegible] 1930

C. HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-3-30

17 I HEREBY CERTIFY, That I attended deceased from 6-30, 1930, to 8-3, 1930, that I last saw her alive on 8-3, 1930, and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pylorus with metastasis to liver

(duration) [illegible] ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? YES

What test confirmed diagnosis? X-ray & Clinical Sym

(Signed) Fred M. Hackenmill, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Aug. 7 1930

20 UNDERTAKER Mrs Chas H. Bailey

ADDRESS 1421 Jeffers St

rec.—1-12-23—M&T—500 Bks.

E 59566 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59566

CERTIFICATE OF DEATH.

45

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balt. Gen Hosp ST. 14 WARD) 20

2-FULL NAME Ophelia Carter

(a) RESIDENCE NO. 1712 McCulloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced
~~HUSBAND OF~~
(or) WIFE OF: John Carter

DATE OF BIRTH (month, day, and year): Feb 14 1896

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	5	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Va

10 NAME OF FATHER: Silas Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

Informant: John Carter

(Address) 1712 McCulloh St.

C. HAMPSON JONES, M. D.

Filed ..... 19 ..... Registrar

C-1330

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/3/30 19

17

I HEREBY CERTIFY, That I attended deceased from 7/23/30, 19, to 8/3/30, 19,

that I last saw h e alive on 8/3/30, 19,

and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of cecum

(?) (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) intestinal obstruction

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/23/30 8/3/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Cushman, M. D.

19 (Address) W. Balt. Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Mila Va

DATE OF BURIAL: Aug 5 19 30

UNDERTAKER: Samuel A Stanley

ADDRESS 598 W Baltimore

Sec.—1-30—M. & T.—300 Blks

59567 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 59567

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 15-21 ST. Margaret Dorsey WARD)

2-FULL NAME Thelma Alston

(a) RESIDENCE NO. 1720 N. Carey st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Married

If married, widowed, or divorced (HUSBAND of or) WIFE of Robert Alston

6 DATE OF BIRTH (month, day, and year) Nov. 2, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	9	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Alfred Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Casey Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hospital Records

(Address)

Filed ..... 19 ..... G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1930, to Aug. 4, 1930, that I last saw h er alive on Aug. 4, 1930, and that death occurred, on the date stated above, at 12.15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Deman, M. D.

8-4, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery

UNDERTAKER Thomas E. Kelson

DATE OF BURIAL Aug 4 1930

ADDRESS 1393 Pennsylvania Ave

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59568

1-PLACE OF DEATH

City of Baltimore: (No. 121 Winter St. St., 23-31 Ward)

2-FULL NAME Mary M. Artish. (C)

(a) RESIDENCE NO. 121 Winter St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 6 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

198 E 59568

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed or divorced (or) WIFE of Lee Artish. (C)

6 DATE OF BIRTH (month, day, and year) January 17, 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	34	6	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Archie Ballard. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Georganna Gibson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Lee Arthis. (C) husband.
(Address) 1132 Clarkson St.

15 Filed ....., 19.... C. HARRISON JONES, M. D.
- 1930 Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of the skull by an axe and incised wound of the throat by a razor. Homicide.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? Yes.
What test confirmed diagnosis? Autopsy & inquest.

(Signed) [illegible], M. D.
(C) 8/3 1930 (Address) 1019 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Aug 6 1930
20 UNDERTAKER Samuel J. Hemsley	ADDRESS 1113 Eddie

C.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59569 E 59569

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE (NO. 671 W. Franklin St. ST., 4-25 W(D)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Miller

(a) RESIDENCE NO. Rock Hall, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Augustus Miller, Jr.

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1888.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
41	9 10	21 19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Denmark

10 NAME OF FATHER Poulsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

Informant Augustus Miller

(Address) 671 W. Franklin St.

Filed ... 19 ... C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/4/30

17 I HEREBY CERTIFY, That I attended deceased from 8/2, 1930, to 8/4, 1930, that I last saw h[er] alive on 8/3, 1930, and that death occurred, on the date stated above, at 6.55 A m.

The CAUSE OF DEATH* was as follows:

Gastric & Hepatic Carcinoma (duration) yrs. 9 mos — ds.

CONTRIBUTORY (Secondary) Cardiac Arteriosclerosis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Friday 1930

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Gustav Goldmann, M. D.

, 19 (Address) 1516 N. Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 8/9/30

UNDERTAKER Harry N. Nitzke 410 Edmondson Ave

ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59570

E 59570

CERTIFICATE OF DEATH.

REGISTERED NO. 10-16 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 949 Homestead St. Ward)

2-FULL NAME William A. Dilshunt

(a) RESIDENCE NO. 2917 Presbury St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of none
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) nov. 25, 1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	64	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work artist

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

10 NAME OF FATHER Geo. R. Dilshunt

11 BIRTHPLACE OF FATHER (city or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Helena Moores

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.

(State or country)

PARENTS

14 Informant Mrs Regina Parks

(Address) 949 Homestead St

Filed 10-5-1930 19 [illegible] JOHN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1 1930, to Aug 5th 1930, that I last saw him alive on Aug 5th 1930, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows: Chronic Parenchymatous Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(durnation) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) K. L. Gordy, M. D.

8-5-1930 (Address) Harford & Aberdeen Circle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Govans Date of Burial aug. 7 1930

20 UNDERTAKER Curley & Co. Inc. ADDRESS 921 N. Eutaw

...c.—1-12-23—M&T—500 Bks.

E 59571

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59571

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen Hosp ST. 16-68 WARD X

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elvin Johnson

(a) RESIDENCE NO. Loraconing Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Wm Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Beeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss M. Eichhorn

(Address) Loraconing Md

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1930

17 I HEREBY CERTIFY, That I attended deceased from 7/24, 1930, to 8/5, 1930, that I last saw h. alive on 8/5, 1930, and that death occurred, on the date stated above, at 9.12 p m.

The CAUSE OF DEATH* was as follows:

Chronic suppurative otitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydremia ? exhaustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 8/1/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Eichhorn, M. D.

, 19 (Address) U. Balto Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Hill Cem. Moscow Md

DATE OF BURIAL Aug 6 1930

20 UNDERTAKER W. J. Tucker Sons

ADDRESS North & Pa

c.—1-30—M. & T.—250 Blks.

E 59572 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59572

CERTIFICATE OF DEATH.

46

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Hanover Mews ST., 4 30 WARD) X

2-FULL NAME Mary Steward

(a) RESIDENCE NO. Ellicott City Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Jas. Steward

DATE OF BIRTH (month, day, and year) Dec 17, 1880

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	9	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER William Horner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Jane Horner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant Jas. Steward

(Address) Ellicott City Md.

Filed AUG 1930, 19 C. HAMPSON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/6/30

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to 8/6, 1930,

that I last saw her alive on 8/6, 1930,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus with metastasis

(duration) unknown. yrs. mos ds.

CONTRIBUTORY (Secondary) Secondary anaemia. Jaundice

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & Laboratory.

(Signed) Henry F. Merrill, M. D.

, 19 (Address) Hanover Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. John's	May 9, 1930
20 UNDERTAKER Easton Sons	ADDRESS) Ellicott City

100 B—50L

E 59573

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59573

CERTIFICATE OF DEATH

194

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 621 A Druid ST., 26 37 WARD

2-FULL NAME Harry Wilkinson

(a) RESIDENCE NO. 621 E Druid ST., 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1890

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer) 0/3
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER James L. Wilkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sallie Kimble

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant M. Alice Campbell

(Address) 3403 Clairmount Ave

15 1930 C. HAMPSON JONES M. D. Registrar

Pat. R.H.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Prostration

(duration) yrs. mos 1 hr ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 Da

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? — What test confirmed diagnosis? History

(Signed) C. C. Grady, M. D. Coroner

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL aug 7 1930

20 UNDERTAKER Lilly & Sons Inc

ADDRESS 403 S. Wolfe St

...c.—1-30—M. & T.—250 Blks

E 59574 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59574

CERTIFICATE OF DEATH. 194

REGISTERED NO. 28.63

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4002 Belvieu Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Ashburner

(a) RESIDENCE NO. 4002 Belvieu Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 9 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles H Ashburner

DATE OF BIRTH (month, day, and year): Oct 26/1864

AGE: Years 65 | Months 9 | Days 11 9 | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: John J McCarthy

11 BIRTHPLACE OF FATHER (city or town) (State or country): London England

12 MAIDEN NAME OF MOTHER: Virginia Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Snow Hill Md.

Informant: Miss Kate McCarthy

(Address) 1307 Linden Ave

C. HAMPSON JONES, M. D.

Registrar

File 1930 19 Roll

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 5. 1930.

17 I HEREBY CERTIFY, That I attended deceased from July 28. 1930, to Aug. 5. 1930, that I last saw h[er] alive on Aug. 5. 1930, and that death occurred, on the date stated above, at 5:50 P. m.

The CAUSE OF DEATH* was as follows:

Cystitis, Cystic, Cardiac Hypertrophy

History about 2 yrs.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Heart, Hypertrophy (duration) 7. 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Exam. & History.

(Signed) J Hunt Bruner, M. D.

(Address) 212 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: Aug 8 1930

20 UNDERTAKER: Harry A Hunscool

ADDRESS: 4204 Ridgewood Ave

...—2-29-28—L. F. S.—500 Bks.

Mekolon (Mekolon) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59575

CERTIFICATE OF DEATH

1/3

E 59575

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 6713 Holabird Ave ST. 36 WARD)

2—FULL NAME Adolph Mekolon

(a) RESIDENCE NO. 6713 Holabird Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 6 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of .....

ATE OF BIRTH (month, day, and year) Feb 20, 1930

GE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5	16	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

IRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Adolph Mekolon

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Niemeck

13 BIRTHPLACE OF MOTHER (city or town) Canada
(State or country) Can.

Informant Adolph Mekolon (Father)

(Address) 6713 Holabird Ave

Filed 1930 C. HAMPSON JONES, M. D., Registrar

Par ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6th 1930

17

I HEREBY CERTIFY, That I attended deceased from Aug 3 1930, to Aug 5 1930, that I last saw him alive on Aug 5 1930 and that death occurred, on the date stated above, at 3:15 A. m.

The CAUSE OF DEATH* was as follows:

Entero - Colitis

(duration) — yrs. — mos. 6 da.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. W. Reier, M. D.

Aug 6 1930 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Christ Evangelical Lutheran Church	Aug 7 1930
20 UNDERTAKER Henry Sander & Sons Inc	ADDRESS Baltimore St. & Broadway

c.—1-30—M. & T.—250 Bks.

✓ Keown
1938 Linden Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59576

CERTIFICATE OF DEATH.

194 E 59576

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 W. Baltimore 19-27 WARD)

2-FULL NAME Emma Jane Swansberry

(a) RESIDENCE NO. 1714 W. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of William H Swansberry

6 DATE OF BIRTH (month, day, and year) Aug 4 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER William Wilson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Mary Slater

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

Informant William H. Swansberry

(Address) 1714 W. Baltimore St.

Filed 1930 Per ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 1st, 1930, to August 6th, 1930,

that I last saw her alive on August 5th, 1930,

and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Cardiovascular disease

General Arteriosclerosis

Reversal (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Heat Exhaustion ?

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis

(Signed) J. W. Keown, M. D.

8/6/1930 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Aug 9 1930

20 UNDERTAKER William Cook — ADDRESS 12 ? St Paul St

c.—1-30—M. & T.—250 Bks.

✓ Dr Keown
1938 Linden Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

59577 194 E 59577

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 307 Robert ST. 14-20 WARD)

2-FULL NAME Nehemiah B. Shorey

(a) RESIDENCE NO. 307 Robert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Martha E Tyler Shor

DATE OF BIRTH (month, day, and year) July 30, 1835

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
95	6	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Maine

10 NAME OF FATHER Nehemiah Shorey

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Ann Chase

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Aquebogue

Informant (Address) Mrs Mable Shorey 307 Robert St

Filed 1930 C. HAMPSON JONES, M. D. Registrar

Per ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to Augt 6th, 1930, that I last saw him alive on August 6th, 1930, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis (senility)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Heart Exhaustion.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis

(Signed) P. W. Keown, M. D.

8/6/1930 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL Aug 8 1930

20 UNDERTAKER Wm Poole — ADDRESS 121 W Saint Paul

...c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59578

74-001 E 59578

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2827 (St.) Wallbrook Ave (WARD) 15-68

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Wood Berryman

(a) RESIDENCE No. 2827 St. Wallbrook Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Berryman

DATE OF BIRTH (month, day, and year) Mar. 15 1874

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	4	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Macon Ga

10 NAME OF FATHER Arthur L. Wood.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brooklyn N.Y.

12 MAIDEN NAME OF MOTHER Juliette McElvin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Macon Ga

Informant Miss Juliette Berryman

(Address) 2827 Wallbrook Ave.

Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1930

17 I HEREBY CERTIFY, That I attended deceased from July 22nd, 1930, to Aug 5, 1930, that I last saw her alive on Aug 5th, 1930, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

Purpura Hemorrhagica ? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. W. Harper, M. D.

, 19 — (Address) 242 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Aug 7 1930
UNDERTAKER	ADDRESS
Wm. J. Tucker & Son	Norcross Ga

C. HAMPSON JONES, M. D. Registrar

T - 1930 Per

c.—1-30—M. & T.—250 Mm

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59579

CERTIFICATE OF DEATH.

65-001 E 59579

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 5017 Cordelia Ave ST., 27 WARD)

2-FULL NAME John Kraly.

(a) RESIDENCE NO. 5017 Cordelia Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 10 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie E. Kraly

DATE OF BIRTH (month, day, and year) Sept. 24, 1855

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	10	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 10 yrs

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER John Kraly.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Schuetz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mr. John A. Kraly. (Address) 4-30 Cornwallis St.

Filed Aug 7 1930 19 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930, to Aug 5, 1930, that I last saw him alive on Aug 5, 1930, and that death occurred, on the date stated above, at 8:15 A m.

The CAUSE OF DEATH* was as follows:

Chr. Lymphatic Leukemia

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Blood exam

(Signed) Dimmer Th Todd, M. D.

8/6, 1930 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Aug 7 1930

20 UNDERTAKER Wm. T. Tedtner Sons ADDRESS Catonsville Md

20—M. & T.—100 B—50L

Dannie Barry.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59580

CERTIFICATE OF DEATH

194 E 59580

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 W Baltimore ST., 19-29 WARD)

2-FULL NAME D. Barry

(a) RESIDENCE No 1319 W. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) 1874

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lab—
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

BIRTHPLACE (city or town) Va
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

Informant Mrs. Monaren

(Address) 1317 W Balto

Filed 1930 Harry [illegible] JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Rat

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. T. Branch, M. D. Coroner

8-6 1930 (Address) Branch

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL 8/8/30.

20 UNDERTAKER E. Jones

ADDRESS 1118 Edmondson Ave

c.—1-30—M. & T.—250 Blks

E 59581 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59581

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1808 N Chester ST., 8/17 WARD)

2-FULL NAME Sofphie Selckmann

(a) RESIDENCE NO. 1808 N Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 7 mos. Br. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

Married, widowed, or divorced

HUSBAND of (or) WIFE of Edward Selckmann Not Living

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Edward Eick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant (Address) 1808 N Chester St

Filed 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1930

17 I HEREBY CERTIFY, That I attended deceased from June 31, 1930, to August 6, 1930,

that I last saw h alive on August 5, 1930,

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Arterial Hypertension

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Physical Examination

What test confirmed diagnosis?

(Signed) Albert Eckenberg, M. D.

8/6, 1930 (Address) 2075 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Aug 8 1930

20 UNDERTAKER Henry Hood's Sons Inc

ADDRESS 1301 E Eager St

...c.—1-12-23—M&T—500 Bks.

E 59582

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 59582

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No. 705 N Patterson Park Ave ST. WARD) 6-10

2-FULL NAME Catherine J Stuppmann

(a) RESIDENCE NO. 705 N Patterson Park Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 20-1905

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
25	24	5	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Joseph J Stuppmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Cath Zoll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

Informant Joseph J Stuppmann

(Address) 705 N Patterson Park Ave

Filed 1930 .19. HAROLD JONES, M. D. Registrar

Dear

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1930

17

I HEREBY CERTIFY, That I attended deceased from July 11, 1930, to Aug 4, 1930, that I last saw her alive on Aug 4, 1930 and that death occurred, on the date stated above, at 6.00 P m.

The CAUSE OF DEATH[a] was as follows:

Chronic Interstitial Nephritis several yrs (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) C R Rotelmy, M. D.

, 19 (Address) 18 W Mt Royal Ave

[a]State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 9 1930
20 UNDERTAKER	ADDRESS
Jos J Stein	152 Eutaw Ave

Cor.—10-10-29—A Co.—100 Bks.

E 59583

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 59583

66

CERTIFICATE OF DEATH

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Found in Carroll Park. St., 4-30 Ward)

2-FULL NAME Albert H. Merson.

(a) RESIDENCE NO. 606 N. Redwood St. St., _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 11 mos. 26 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Divorced.

5a If ~~married, widowed~~, or divorced HUSBAND of (or) WIFE of Ella Merson.

6 DATE OF BIRTH (month, day, and year) August 9, 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	51	11	26 25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Glass blower.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas L. Merson.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Caroline Freeman.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Carroll Co. Md.

14 Informant Mrs. Josephine L. Kenney. (sister)
(Address) 1728 Aiken St.

Filed 1930 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4th. 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

_____ (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) _____

_____ (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto W. Leonhardt, M. D.

8/14 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Aug 15 1930
20 UNDERTAKER Henry Lutz	ADDRESS 1203 N. Broadway

30—M. & T.—100 B—50L

E 59584

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59584

CERTIFICATE OF DEATH

112

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 909 E Madison ST., 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bettie Hauser Nelson

(a) RESIDENCE NO. 909 E Madison ST., WARD E.B.B.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fenal.	Color.	Married.

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1890

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
[redacted]	40			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Rag Factor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

0816

BIRTHPLACE (city or town) (State or country) V.a.

10 NAME OF FATHER James. Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Sarah Jones

13 BIRTHPLACE OF MOTHER (city or town) V.a. (State or country) unknown

Informant Laborance [redacted]

(Address) 909 E [redacted] son st.

Filed ....(192) [redacted] Registrar

7-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Indigestion Cirrhosis of Liver

(duration) ....yrs. ....mos. — ds.

CONTRIBUTORY (Secondary) Ac Cardiac Dilation

(duration) ....yrs. ....mos. — ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? By Visions

(Signed) G C Glades, M. D.
Coroner

, 19 (Address) 1430 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cemetery

DATE OF BURIAL 8/7 1930

20 UNDERTAKER Edward. Bryant.

ADDRESS 1631 Orleans St

c.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59585 ✓ E 59585

CERTIFICATE OF DEATH.

74-002

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO. ST. 4 WARD)

2-FULL NAME Herbert Harris

(a) RESIDENCE NO. 229 Arch ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of -

DATE OF BIRTH (month, day, and year) March 5, 1[illegible]

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	5		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

BIRTHPLACE (city or town) Balto.
(State or country) Md.

10 NAME OF FATHER George Harris

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) Washington, D.C.
(State or country)

Informant Records of
(Address) Balto. City Hosp.

Filed ..... 19 [illegible] Registrar

7-1930.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5-30

17 I HEREBY CERTIFY, That I attended deceased from 4-28-30, 19..., to 8-5-30, 19...,

that I last saw h[illegible] alive on 8-5-30, 19...,

and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Thrombosis, left middle cerebral artery.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1. Hospital 2. Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget, M. D.

8.6, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cement

DATE OF BURIAL 8-8-30

20 UNDERTAKER Edward Bryant

ADDRESS 1631 Orleans

c.—1-30—M. & T.—200 Blks

E 59586 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59586

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ST. 10-14 WARD)

2-FULL NAME Robert T. Hall

(a) RESIDENCE NO. 1012 McKim St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Magretta

DATE OF BIRTH (month, day, and year) 1856

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0 to

(c) Name of employer

IRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Harry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarajane ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Records of

(Address) Balto. City Hosp.

Filed 7-1930 Harry JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5-30

17 I HEREBY CERTIFY, That I attended deceased from 7-5-28, 19..., to 8-5-30, 19..., that I last saw him alive on 8-5-30, 19..., and that death occurred, on the date stated above, at 2:20 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis UNKNOWN.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padget, M. D.

8-5, 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemtd.

DATE OF BURIAL Aug 8 1930

20 UNDERTAKER Edwards Bryant

ADDRESS Harlem

30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59587

CERTIFICATE OF DEATH

194 E 59587
REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 521 N. Gilmor, 19-7 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Brown

(a) RESIDENCE NO 521 N. Gilmor WARD
(Usual place of abode) (if non-resident give city or town and State)
Length of residence in city or town where death occurred 1 yr. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Edna Brown

DATE OF BIRTH (month, day and year) Oct 31-1897

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
32	32	9	4	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Wm Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hattie Bridgen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Hattie Matthews
(Address) 1060 N. Lafayette

Filed 1930 C. HAMILTON JONES, M. D.
192 Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 4th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(inquest, autopsy or inquiry) thereon and from the evidence obtained by said ....(inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH was as follows:

Heat Prostration

(duration) ....yrs. few hours ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Regular

(Signed) H. Gilbert Smith, M. D. Coroner

Aug 4th 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Aug 7, 1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

...c.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59588 E 59588

CERTIFICATE OF DEATH. 31

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 N. Glover ST., 7-10 WARD)

2-FULL NAME Edward H. Booth

(a) RESIDENCE No. 502 N. Glover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 19, 1865.

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
64	7	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) 047

(c) Name of employer

BIRTHPLACE (city or town) Balto.
(State or country) Md.

10 NAME OF FATHER John H. Booth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary A. Itson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Mrs. E. Weidner
(Address) 502 N. Glover St. [illegible]

Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to 8-5, 1930, that I last saw h[illegible] alive on 8-5, 1930, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis. Mitral Regurgitation

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Pul Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

8-6, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery. DATE OF BURIAL: Aug. 8 1930

20 UNDERTAKER: Wm. C. Black ADDRESS: 927 N. Broadway

c.—1-30—M. & T.—250 Blks.

59589
36 342

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59589

CERTIFICATE OF DEATH.

X 100-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 1217 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leslie Givens

(a) RESIDENCE NO. 1605 St. Paul ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 8 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Clarrie Givens

DATE OF BIRTH (month, day, and year) March 23/94

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	4	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Ky

10 NAME OF FATHER John Givens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky

12 MAIDEN NAME OF MOTHER Mapa Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky

Informant (Address) Friends JOHNS HOPKINS HOSPITAL

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 dc 30

17

I HEREBY CERTIFY, That I attended deceased from April 24, 1930, to Aug 6, 1930, that I last saw him alive on Aug 6, 1930, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pneumonia, Bronchial

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Lung Abscess over

(duration) ..... yrs. 5 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Examination

(Signed) George B. Dunton, M. D.

, 19 (Address) Aug 6th 1930 Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chattanooga Tenn — DATE OF BURIAL Aug 7 1930

20 UNDERTAKER F. M. Cook — ADDRESS 1217 St Paul

E. L. JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59590 — REGISTERED NO. E 59590

74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 910 E Spaulding ave 7-27-56 St., Ward)

2-FULL NAME Mrs Johanna C Ritter

(a) RESIDENCE NO. 3106 Spaulding St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Henry Ritter

6 DATE OF BIRTH (month, day, and year) Oct 14th 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	70	10	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Theodor Kroh

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Fuchs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Minna Loabl
(Address) 2305 Kreoak Rd

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

8-6, 1930 (Address) 3422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 8/8/1930

20 UNDERTAKER Wm Cook 1217 — ADDRESS St Paul

c.—1-30—M. & T.—250 Blks.

E 59591 ✓ E 59591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Bishop Road ST., 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Evans Sperry

(a) RESIDENCE NO. 6 Bishop Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Was attended by Dr Harry L Black.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or) WIFE of Lee Wilson Sperry

DATE OF BIRTH (month, day, and year) Apr 18 1854

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	3	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Architect

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Georgetown D.C.

10 NAME OF FATHER David Anem Sperry

11 BIRTHPLACE OF FATHER (city or town) (State or country) America ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) America

Informant Mrs Lee Wilson Sperry

(Address) 6 Bishop Rd.

Filed 1930 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1930

17 I HEREBY CERTIFY, That I attended deceased from ..... to ..... ; that I last saw h alive on ..... , 19..... ; and that death occurred, on the date stated above, at 7 30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue

(duration) 1 yr 10 mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry L. Thomas M.D.

, 19 (Address) 1201 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Aug 8 1930

UNDERTAKER Stewart & Mowen Co

ADDRESS 108 W. North Ave

.—2-29-28—L. F. S.—500 Blks. Katherine Sledge

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

59592 — 32 E 59592

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 909 E. Madison ST., 10-14 WARD)

2—FULL NAME Katherine Sledge

(a) RESIDENCE NO. 909 E Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
	Col	Single

married, widowed, or divorced HUSBAND of (or) WIFE of — March 13 - 1925

TE OF BIRTH (month, day, and year) March 13 - 1925

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	4	23	

CUPATION OF DECEASED

a) Trade, profession or particular kind of work

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

RTHPLACE (city or town) Richmond Va

State or country)

0 NAME OF FATHER Major Sledge

1 BIRTHPLACE OF FATHER (city or town) N. C.

(State or country)

2 MAIDEN NAME OF MOTHER Laura Williamson

3 BIRTHPLACE OF MOTHER (city or town) S. C.

(State or country)

Informant Laura Williamson

(Address) 909 E. Madison

Filed 1930 Bill JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6, 30

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to Aug 6, 1930,

that I last saw h alive on Aug 5, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

acute Tubercular Meningitis

(duration) 0 yrs. 0 mos. 13 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) J Edward Fisher, M. D.

8-7, 1930 (Address) 1612 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvery Cemetery	8/8/30
20 UNDERTAKER	ADDRESS
Robert E. Williams	1515 Mt Elderry Av

1-80—M. & T.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59593 ✓

CERTIFICATE OF DEATH.

E 59593

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2102 McCulloh ST., 14-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Audrey L. Loomer

(a) RESIDENCE NO. 2102 McCulloh ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 22 1893

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	11	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Galesville Md

10 NAME OF FATHER Henry Loomer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Gautier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Viola Boyd

(Address) 2102 McCulloh St

Filed 7-1930 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-4-1930

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to Aug 4, 1930, that I last saw h[illegible] alive on Aug 3, 1930 and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. H. Howells M. D

, 19 (Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	8-7 1930
UNDERTAKER	ADDRESS
Samuel Bromley	578 N Bridge

...c.—1-30—M. & T.—250 Blks.

E 59594

59594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

...TY OF BALTIMORE: (NO. ... ST 16 WARD)

2-FULL NAME Lena Harrison

(a) RESIDENCE NO. 1210 N Stricker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

...EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

...ATE OF BIRTH (month, day, and year) 1887

...GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
43		—	—	

...CCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ?
(b) General nature of industry, business, or establishment in which employed (or employer) ?
(c) Name of employer ?

...IRTHPLACE (city or town) ?
(State or country) Virginia

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Belinda Harrison

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Virginia

Informant Russell Taylor
(Address) Baltimore City Hosp.

Filed 7-1930 C. H. JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-4-1930

17 I HEREBY CERTIFY, That I attended deceased from 6-22, 1927, to 8-4, 1930, that I last saw her alive on 8-4-, 1930, and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical exam.

(Signed) Fred M. Ducknall, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 8/7 1930

20 UNDERTAKER Samuel T. Hensley

ADDRESS 78 W Biddle

c.—1-30—M. & T.—250 Bks.

E 59595 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59595

CERTIFICATE OF DEATH. X 32

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver St., 9-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lillian Chenoweth

(a) RESIDENCE NO. Fullerton Md R.F.D #1 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

If married, widowed, or divorced HUSBAND of or) WIFE of Samuel Chenoweth

DATE OF BIRTH (month, day, and year) Jan. 21 1889

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
41	41	6	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer At Home

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER James J Mac

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna McCann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant R. W. Mac. (Address) 1417 Vernon St Harford Rd

Filed 7-1930 19 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1930, to Aug 7, 1930, that I last saw h alive on Aug 7, 1930, and that death occurred, on the date stated above, at 10 40 A m.

The CAUSE OF DEATH* was as follows: Tuberculous Meningitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Vincent M. Fleming M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestnut Grove — DATE OF BURIAL Aug 9 1930

UNDERTAKER D. Foley Burns Sons — ADDRESS Towson

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59596

CERTIFICATE OF DEATH

113

E 59596

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 481 W. Henrietta St. St., 2331 Ward)

2-FULL NAME Juanita V. Miles. (C)

(a) RESIDENCE NO. 481 W. Henrietta St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 4, 1930

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	0	5	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Wallace Miles. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina.

12 MAIDEN NAME OF MOTHER Eva Thomas. (C)

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Maryland.

14 Informant Eva Miles. (C) mother.
(Address) 481 W. Henrietta St.

15 Filed 8-7-1930 C. H. Jones M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhoea.
Exhaustion.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto E. Reinhardt, M. D.

8/7, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion et	Aug 7 1930
20 UNDERTAKER	ADDRESS
W. L. Brown & Son	108 W. Monte

...—8-16-29—L. F. S.—100 Blks.

59597

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59597

CERTIFICATE OF DEATH

× 89

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.) 1309 Orleans St. (WARD) 5-8

2—FULL NAME Nannie Johnson

(a) RESIDENCE NO. 1309 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

If married, widowed, or divorced, HUSBAND of (or) WIFE of Jas Hilleary Johnson

ATE OF BIRTH (month, day, and year) 12/11/877

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Samuel Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nannie Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Victoria Johnson

(Address) 1309 Orleans St

Filed 19 C. MASON JONES, M. D., Registrar.

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1930

I HEREBY CERTIFY, That I attended deceased from July 29, 1930, to July 29, 1930,

that I last saw ... alive on July 29, 1930,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 da.

CONTRIBUTORY (Secondary) Heart Exhaustion Cardiac Renal Disease

(duration) ... yrs. ... mos. 4 da.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? ... Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) Jas H Hilleary, M. D.

(Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Aug 1 1930

20 UNDERTAKER E. Edward Bryan

ADDRESS 1631 Orleans St

Spec.—1-10-21—M&T—1500 Blks.

59598

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-023 E 59598

REGISTERED NO.

1-PLACE OF DEATH Franklin Square Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. Fayette & Calhoun ST., 19 WARD)

2-FULL NAME Baby Boy Michael John McMahon

(a) RESIDENCE NO. Fort Hayes Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 6, 1930

7 AGE — Years — Months 1 Days If LESS than 1 day 15 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md. (State or country)

PARENTS

10 NAME OF FATHER Geo. F. McMahon

11 BIRTHPLACE OF FATHER (city or town) Rome (State or country) Italy

12 MAIDEN NAME OF MOTHER May Belle Harkins

13 BIRTHPLACE OF MOTHER (city or town) Burlington (State or country) Kansas

14 Informant Geo. F. McMahon (Address)

15 Filed AUG 7 - 1930 19

C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-7-1930

17 I HEREBY CERTIFY, That I attended deceased from 8-6, 1930, to 8-7, 1930, that I last saw him alive on 8-7, 1930, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Respiratory Failure

Primary cause Spina Bifida at birth

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Intra uterine

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) M. B. Schreiber, M. D.

19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Va

DATE OF BURIAL 8/8, 1930

UNDERTAKER Georgetown Funeral

ADDRESS

c.—1-30—M. & T.—250 Blks.

E. Henri 5164 Caldwell

HEALTH DEPARTMENT—CITY OF BALTIMORE

59599 ~~E 59599~~

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2230 Fredk Ave ST., 70-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Steup

(a) RESIDENCE NO. 2230 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Steup

DATE OF BIRTH (month, day, and year) Feb 12th 1882

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	5	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Hungary

10 NAME OF FATHER Henry Steup

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Barbara Seipp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Anna Steup

(Address) 2230 Frederick Ave

Filed 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5th 30

17 I HEREBY CERTIFY, That I attended deceased from March, 1929, to August 5, 1930, that I last saw h— alive on Aug 1st, 1930, and that death occurred, on the date stated above, at 2 — O. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) General Metastasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) H. E. Mann, M. D.

Aug 7, 1930 (Address) 516 Caldwell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Aug 8th 1930

20 UNDERTAKER J. A. Pleasant

ADDRESS 1850 N. Gilmor St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59600 E 59600

CERTIFICATE OF DEATH.

14-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 410 S. Smallwood St. (Ward) 20-69

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kagle

(a) RESIDENCE NO. 410 S. Smallwood St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jennie Crough Kagle

6 DATE OF BIRTH (month, day, and year) Nov. 25 1847

7 AGE Years 82 Months 8 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

PARENTS

14 Informant (Address) Charles Kagle 410 S. Smallwood St

15 Filed ..... 1930 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1930

17 I HEREBY CERTIFY, That I attended deceased from July 24. 1930. to Aug 5. 1930.

that I last saw him alive on Aug 4. 1930.,

and that death occurred, on the date stated above, at 3.20 P. m. D.S.T.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (apoplexy)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. J. O'Neill M. D.

8/6. 1930 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Aug 8 1930

UNDERTAKER E. O. Wagner

ADDRESS 1850 N. Gilmor St

Spec.-7-17-26—A Co.—200 Blks.

E 59601

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59601

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

1-PLACE OF DEATH Aged Womens Home

City of BALTIMORE: (No. 1404 W Lexington St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Fodwell

(a) RESIDENCE NO. 1404 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1, 1849

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	80	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Wm Gilbert

11 BIRTHPLACE OF FATHER (City or town)

(State or country) N G

12 MAIDEN NAME OF MOTHER Ellen Rinly

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Baltimore Md

14 Informant Mrs H E Baker

(Address) 1404 W Lexington

15 1930 C. BRANSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1930 to Aug 6, 1930

that I last saw h alive on June 2, 1930

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) senile stroke 9 apoplexy post yr.

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed) Edwin P Smith M. D.

, 19 (Address) 1115 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Creek Cem Washington D C

Date of Burial Aug 8 1930

20 UNDERTAKER George J Smith

ADDRESS Hollins

c.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59602 90 E 59602

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Chesley Ave.

(If death occurred in hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 3122 Chelsey ST., WARD) 27-43

2—FULL NAME Annie Jr Simmel 6 Chesley Ave.

(a) RESIDENCE NO. 3122 Chelsey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Simmel

ATE OF BIRTH (month, day, and year) Jan. 5-1864

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	5		

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

IRTHPLACE (city or town) Balto Md.
State or country)

0 NAME OF FATHER Andrew - Shannon

1 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

2 MAIDEN NAME OF MOTHER Louise Blakeney

3 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

Informant John J. Simmel

(Address) 3122 Chelsey Ave

Filed 8-19-1930 O. H. THOMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 - 1930

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to Aug 5, 1930, that I last saw h/ alive on Aug 5, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Valvular Rheumatic Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Lewis M. D.

8/6, 1930 Address 42 Westport Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL 8/8 1930

20 UNDERTAKER D. L. J. Rauch

ADDRESS 6405 Belair

c.—1-30—M. & T.—250 Blks.

Seidner
4900 Belair Rd

E 59603 HEALTH DEPARTMENT—CITY OF BALTIMORE Hand E 59603

CERTIFICATE OF DEATH.

5, 8 138

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 431 N. Gay ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Louise Schmidtmann

(a) RESIDENCE NO. 431 N Gay ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) Aug 3, 1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	0	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER August Schmidtmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Engel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant W. H. Schmidtmann

(Address) 527 E 20th Street

Filed Aug 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1930 to Aug 6th, 1930

that I last saw h[illegible] alive on Aug 5th, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH[a] was as follows:

Pelvic Abscess

1 over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M.D.

Aug 8, 1930 Address 4900 Belair Rd

[a]State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 9 1930
UNDERTAKER	ADDRESS
William Cook	247 N Gay

c.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59604

CERTIFICATE OF DEATH.

27-48 46

L 59604

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No.) Aisquith (St.) (Ward) 25

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. McKee

(a) RESIDENCE NO. 4718 York Road (St.) (Ward)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced (HUSBAND OF or) WIFE of Marion McKee

DATE OF BIRTH (month, day, and year) Aug 6 1888

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42	0	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Michael Scully

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Whitely

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Marion McKee

(Address) 4718 York Road

C. HARRISON JONES, M. D.

Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-7-30

17 I HEREBY CERTIFY, That I attended deceased from 6-25-30, 19..., to 8-7-30, 19...,

that I last saw her alive on 8-7-30, 19...,

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Cancer Cervix

Uteri

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hse

Did an operation precede death? yes Date of 7-15-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) N B Handy, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Aug 9 1930

20 UNDERTAKER Tom Cook

ADDRESS 1217 St Paul St

10—M. & T.—100 11—601.

E 59605

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59605

CERTIFICATE OF DEATH

188-103

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lt's Hosp ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lottie V Moore 10-14

(a) RESIDENCE NO 815 E Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
m	W	Child

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Jan 1-1926

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	7	5	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Sam. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Clark (Ott ?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Samuel Moore

(Address) 815 E Eager St

88 [illegible] H. [illegible] JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: While boarding ride on side of auto fell off & was run over by auto truck

(duration) yrs. 1 mos ds. over

CONTRIBUTORY (Secondary) fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Front 815 Chase

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) H. Krause, M. D. Coroner

8-7 1930 Address 2931 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 8/9/30 19

20 UNDERTAKER George J. Ruth Inc

ADDRESS 1705 Harford Ave

30—M. & T.—100 M—501.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59606 ✓ E 59606

CERTIFICATE OF DEATH

90

E 59606
1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) Provident Hosp ST., ... WARD 20

2-FULL NAME Spencer Jones 14

(a) RESIDENCE NO 1801 Linwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Jones

DATE OF BIRTH (month, day, and year) Oct 1 - 1880

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	10	7	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Cornelius Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va "

12 MAIDEN NAME OF MOTHER Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va "

14 Informant Dora Jones
(Address) 1801 Linwood St

Filed 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart
(duration) ... yrs. Sudden

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. G. Smith, M. D. Coroner

(Address) Aug 7th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cmtry

20 UNDERTAKER Geo. T. A. Gibson

DATE OF BURIAL Aug. 10 1930

ADDRESS 1735 Druid Hill Ave

Spec.—1-30—M. & T.—250 Blks.

E 59607 ✓ E 59607

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-003

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD) 12

2-FULL NAME Anna Mary Schmidt

(a) RESIDENCE NO. 1121 N. Milton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 4, 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto. Md.
(State or country)

10 NAME OF FATHER John Schmidt

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Lewis

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

Informant Mrs. Schmidt
(Address) 1121 N. Milton Ave

Filed Aug 8 - 1930 H. M. PERKINS JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6, 1930, to Aug. 7, 1930, that I last saw h.e. alive on Aug 7, 1930, and that death occurred, on the date stated above, at 10 = A. m.

The CAUSE OF DEATH* was as follows:

Congenital Diathysis of Recti Muscles, with Herniation of Abdominal Viscera

(duration) yrs. mos 3 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug. 7, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George H. Yeager, M. D.

8/7, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL Aug 9 19

20 UNDERTAKER F. A. Krauseson — ADDRESS 203 Mon

...-2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59608

CERTIFICATE OF DEATH

179 E 59608

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Maryland Gen Hospital (ST.) (WARD)

2—FULL NAME James Frances Slater

(a) RESIDENCE NO. 1411 Anchor ST., 24-33 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) June 4-1930

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	7	7	3	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

9 NAME OF FATHER

10 BIRTHPLACE OF FATHER (city or town) (State or country)

11 MAIDEN NAME OF MOTHER Sadie Slater

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Maryland Gen Hosp

(Address) Annapolis Road

Filed 1930 C. D. THOMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-7-1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 -, 1930, to Aug 8 -, 1930, that I last saw him alive on Aug 8, 1930 and that death occurred, on the date stated above, at 1:50 P m.

The CAUSE OF DEATH* was as follows:

Extensive Burns of the body and extremities - 1st 2nd & 3rd Degree -

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where did disease contracted if not at place of death? At home

Did an operation precede death? No Date of

What diagnosis confirmed by? No

What test confirmed diagnosis? Clinical -

(Signed) Robert V. Clements, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lancaster County Va.	Aug 8th 1930
20 UNDERTAKER	ADDRESS
E. C. Krause & Son	703 Hamm

Cor.—10-10-29—A Co.—100 Bks.

59609

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

182 E 59609

REGISTERED NO.

1-PLACE OF DEATH Pronounced dead Bklyn City Hosp.

City of Baltimore: (No. Dundalk St., Ward) 6-10

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Ribnick

(a) RESIDENCE NO. 2321 E. Fairmount Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1 1913

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	17	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Errand boy
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) New York

PARENTS

10 NAME OF FATHER Harry

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Ribnick family
(Address) 2321 E. Fairmount ave

Filed 8-1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/8/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

8/8/30 J C Hastings M. D.

(Signed)

19 (Address) 143 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hebron Cemetery

DATE OF BURIAL 8-8-1930

20 UNDERTAKER Jack Lewis, 1439 E Balto

ADDRESS

...c.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59610

CERTIFICATE OF DEATH

161-002 E 59610

REGISTERED NO. 15-21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

ITY OF BALTIMORE. (No. 1629 Gilmor ST., WARD)

2—FULL NAME Infant of Geneva Avery

(a) RESIDENCE NO. 1629 Gilmore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 8.6.30

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1/2 hour			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Balto Md
(State or country)

10 NAME OF FATHER Oscar Avery

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Geneva Alexander

13 BIRTHPLACE OF MOTHER (city or town) N C
(State or country)

Informant Oscar Avery

(Address) 1629 E. Gilmor St.

8-1930 [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1930 to Aug 6, 1930

that I last saw h[illegible] alive on 8-6-30 19

and that death occurred, on the date stated above, at 2 PM m.

The CAUSE OF DEATH* was as follows:

Strangulation due to umbilical cord around neck.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. R. Boykin, M. D.

, 19 (Address) 1512 Gilmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Aug 8 1930

20 UNDERTAKER Thomas E. Kelson.

ADDRESS 1303 Presstman St

c.—1-30—M. & T.—350 Blks.

E 59611 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59611

33

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1379 N. Gilmor ST., WARD) 15-22

2-FULL NAME Sadie H. Chambers

(a) RESIDENCE NO. 1379 N. Gilmor ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of Charles Chambers

DATE OF BIRTH (month, day, and year) July 26, 1881

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	0	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Howard Co Md

10 NAME OF FATHER Moses Hackett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Harriett Hackett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant Charles Chambers
(Address) 1379 N. Gilmor St

FILED ..... 19 30 MARY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5/30

17 I HEREBY CERTIFY, That I attended deceased from July 28th 1930 to Aug 5th 1930.
that I last saw h.. alive on Aug 4th 1930
and that death occurred, on the date stated above, at 7.30 P. m.
The CAUSE OF DEATH* was as follows:

Peritoneal Tuberc.
Pulosis

(duration) ..... yrs. 7 mos ..... ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus ?
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

(Address) 927 Mt. Rov.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Aug 8 1930

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1307 Pennsylvania Ave

c.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59612

CERTIFICATE OF DEATH.

113 E 59612

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Provident Hospital ST., 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Williams

(a) RESIDENCE No. 530 Oxford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 30 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER Robert Williams

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Hattie Robinson

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

Informant Dolly Williams

(Address) 530 Oxford st

Filed AUG 8 - 1930 CAMPBELL JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930, to Aug 6, 1930, that I last saw him alive on Aug 1, 1930, and that death occurred, on the date stated above, at 3 10 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Diarrhea Malnutrition Dehydration (duration) yrs. 1 mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Carroll M McClain, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Aug 8 1930

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1925 Washington ave

c.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59613

CERTIFICATE OF DEATH

129 E 59613

REGISTERED NO.

1—PLACE OF DEATH

TY OF BALTIMORE: (No. 923 N. Bond ST., WARD) 7-13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Phillips

(a) RESIDENCE NO. 923 N. Bond. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	W.	married.

If married, widowed, or divorced HUSBAND of (or) WIFE of Frances E. Phillips

ATE OF BIRTH (month, day, and year) Nov-8-1852

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	8	29	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Charles Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Mary Hunter.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Emmorsburg Md.

Informant. Harry E. Phillips

(Address) Relay, Md.

Filed 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6-1930

17 I HEREBY CERTIFY, That I attended deceased from August 4-, 1930, to August 6, 1930, that I last saw h alive on August 6-, 1930 and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) none.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis & Symptoms.

(Signed) Chester Rolands, M. D.

8-7-1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 9 1930
UNDERTAKER	ADDRESS 1203
E. Henry Lutz	N. Broadway

...c.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59614

CERTIFICATE OF DEATH

117 E 59614

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. ..... ST., ... WARD) 12-20

2-FULL NAME Virginia Smith

(a) RESIDENCE NO. 2607 Maryland Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
...ale	White	Divorced

If married, widowed, or divorced HUSBAND of (or) WIFE of ?

ATE OF BIRTH (month, day, and year) May 23 1894

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
41		2	14	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ? 037

(c) Name of employer ?

IRTHPLACE (city or town) Newburg
(State or country) W. Va.

10 NAME OF FATHER Charles ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Va.

12 MAIDEN NAME OF MOTHER Ella ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Va.

Informant Records Baltimore City Hosp.
(Address)

8-1930 ...r ... JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-7-30

17 I HEREBY CERTIFY, That I attended deceased from 8-3-, 1930, to 8-7, 1930, that I last saw h[illegible] alive on 8-7, 1930, and that death occurred, on the date stated above, at 3:19 P m.

The CAUSE OF DEATH* was as follows:

Gangrenous appendicitis

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Paralytic Ileus

(Duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 8-3-30

Was there an autopsy? no

What test confirmed diagnosis? Operation.

(Signed) Hurd M. Duckwall, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newburg West Va

DATE OF BURIAL 8/8 1930

UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Baltimore Md

...r.—8-16-29—L. F. S.—100 Bks.

E 59615

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

E-59615

CERTIFICATE OF DEATH

18-26 REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 202 N Amity ST., WARD)

2—FULL NAME John Jackson

(a) RESIDENCE NO. 202 N Amity ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

ngth of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Jackson

DATE OF BIRTH (month, day, and year) 1879 X

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hod Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) 0-35

(c) Name of employer

IRTHPLACE (city or town) (State or country) Frederick Co Md

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Julia Jackson

(Address) 202 N. Amity

8-1930 SIMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6/30.

17

I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to Aug 6, 1930, that I last saw him alive on Aug 5, 1930 and that death occurred, on the date stated above, at 7 A.M. m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 14 ds.

over

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Jas L Hooper, M. D.

8/6, 1930 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tappahannock, Essex Co. Va

DATE OF BURIAL Aug 8, 1930

20 UNDERTAKER Mrs. Kate R. Williams

ADDRESS 3224 Schroeder St

c.—1-30—M. & T.—250 Blks.

Oakley

E 59616 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59616

CERTIFICATE OF DEATH.

18-26 138

1-PLACE OF DEATH St. Josephs Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. Catonsville Ave ST., S WARD)

2-FULL NAME Elizabeth Oakley

(a) RESIDENCE NO. 1073 W. Fayette ST., S WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
W. Fem	Colored	married

If married, widowed, or divorced HUSBAND of or) WIFE of John Oakley

DATE OF BIRTH (month, day, and year) Jan 5, 1890

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	7		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Calvert Co Md

10 NAME OF FATHER John Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Frances Freeland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

Informant James Dixon

(Address) 1073 W Fayette St

Filed 8 1930 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5-30.

17 I HEREBY CERTIFY, That I attended deceased from 7-30, 1930, to 8-5, 1930.

that I last saw h[illegible] alive on 8-5-30, 19....

and that death occurred, on the date stated above, at 12 35 P m.

The CAUSE OF DEATH* was as follows:

Multiple uterine fibroids

Bilat. Tubo-Ovarian abscess.

Bilat. Multilocular Cystic Ovaries.

(duration) 1 mo. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation over

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same.

Did an operation precede death? yes Date of 8-5-30.

Was there an autopsy? no

What test confirmed diagnosis? Operation.

(Signed) M B Wheatley, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cemetery

DATE OF BURIAL Aug 8, 1930

UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

c.—1-30—M. & T.—250 Blks

E 59617

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59617

CERTIFICATE OF DEATH.

138

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No. Provident Hospital ST., WARD)

2-FULL NAME Mabel Smith 18-26

(a) RESIDENCE No 1123 Lasalle Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Smith

DATE OF BIRTH (month, day, and year) July 23, 1907

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) Balto
(State or country) Md

10 NAME OF FATHER Thomas Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Estella Fridland

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

Informant Alfred Smith
(Address) 1123 Lasalle Ave

Filed 1930 G. Hamilton Jones M D
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 3 30

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Aug 3, 1930, that I last saw h.. alive on Aug 3, 1930, and that death occurred, on the date stated above, at 6 00 a. m.

The CAUSE OF DEATH* was as follows:

Grand Centinitis
Edema Abscess over

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8 1 30

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. L. Jackson, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Mt Auburn Cemetery

DATE OF BURIAL
Aug 8, 1930

20 UNDERTAKER
Mrs Kate R Williams

ADDRESS 3227 Edmondson Ave

c.—1-30—M. & T.—250 Bks.

E 59618 · HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 38 E 59618

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospts. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. Balto Md ST., WARD) 9-46

2-FULL NAME George Kohlhafer

(a) RESIDENCE NO. 1600 E 31st St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Separated

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) July 25 1886

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44		12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work O & C

(b) General nature of industry, business, or establishment in which employed (or employer) Mechanic

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER George Kohlhafer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophie Bayler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Records Balto City Hosp

(Address)

Filed ..... 19 ..... C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6-30

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1928 to Aug 6, 1930 that I last saw him alive on Aug 5, 1930 and that death occurred, on the date stated above, at 5.35 A m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paresis, Luetic Infection (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Pathological & Clinical

(Signed) Mary F. Hospital M. D.

8/6, 1930 (Address) Balto City Hospts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 8 1930
20 UNDERTAKER	ADDRESS
John F Denny	715 Light St

...-2-29-28—L. F. S.—500 Bks.

Brengle.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59619

CERTIFICATE OF DEATH

117

E 59619

REGISTERED NO. .....

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. Maryland Gen. Hospital ST., WARD)

2—FULL NAME John Brengle 19-26

(a) RESIDENCE NO. 1316 West Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	white	married

f married, widowed, or divorced HUSBAND of (or) WIFE of Virgie M Brengle

ATE OF BIRTH (month, day, and year) Jan-24-1880

GE 50 Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
49	6	13	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate Broker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

IRTHPLACE (city or town) Fredrick (State or country) Maryland

10 NAME OF FATHER William Henry Brengle

11 BIRTHPLACE OF FATHER (city or town) Fredrick (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Margaret Hoff

13 BIRTHPLACE OF MOTHER (city or town) Fredrick (State or country) Maryland.

Informant Maryland Gen. Hospital (Address) med

Filed ..... 19... C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-9-1930

17 I HEREBY CERTIFY, That I attended deceased from 8-5-1930, 1930, to 8-9-1930, 19...,

that I last saw h... alive on 8-9-1930, at ...m.

and that death occurred, on the date stated above, at 2:00 A m.

The CAUSE OF DEATH* was as follows: (Ruptured)

Acute Gangrenous Appendicitis

General Septic peritonitis

(duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of 8-6-1930

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) Robert Clements, M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Aug 9 1930
20 UNDERTAKER John O. Mitchell & Son	ADDRESS 1911 Eutaw Place

30—M. & T.—100 B—60L

E 59620

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59620

CERTIFICATE OF DEATH

194

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 517 N. Schroeder WARD) 18.26

2-FULL NAME Edward Eyrgalls

(a) RESIDENCE NO 517 N. Schroeder ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of no

7 DATE OF BIRTH (month, day, and year) Jan 31 - 1882

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	6	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer) 015
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co Md

10 NAME OF FATHER Ed.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot Co Md

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura Nelson

(Address) 517 Wilmer Pl

Filed 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat prostration

(duration) ..... yrs. few hours.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) H. Hoffstick, M. D. Coroner

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 8/8 1930

UNDERTAKER Samuel Kennedy ADDRESS 1778 Belle

E 59621

CERTIFICATE OF DEATH

90 E 59621

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 N Milton Ave ST., WARD) 6-10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lawrence J. Stadter

(a) RESIDENCE NO. 4 N Milton ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

a If married, widowed, or divorced RUSBAND of (or) WIFE of Estella Stadter

DATE OF BIRTH (month, day, and year) May 6-1879

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	3	0	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retained Special

(b) General nature of industry, business, or establishment in which employed (or employer) Police

(c) Name of employer 061

BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Geo Stadter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Stadter

(Address) 128 N Eutaw

15 AUG 8 - 1930 C. H. JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6. 30

17 I HEREBY CERTIFY, That I attended deceased from February 1930 to Aug 6, 1930, that I last saw h. alive on Aug 6, 1930 and that death occurred, on the date stated above, at 120a m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) M. L. Mazer, M. D.

8/8, 1930 (Address) 261 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 9 1930
20 UNDERTAKER	ADDRESS
J. Stevenson-156	Eutaw

1-12-23—M&T—500 Blks.

E 59622 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 59622

1-PLACE OF DEATH Belvedere ✓ Greenspring Ave's Hebrew Home for Aged ✓ Infirm. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME S. Bale Ginsberg 27-54

(a) RESIDENCE NO. Belvedere ✓ Greenspring Ave's ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: Nathan

DATE OF BIRTH (month, day, and year): 1852

AGE: Years 78; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

Informant .....

(Address) .....

Filed 8-1930 H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 7 1930

17

I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to August 7, 1930, that I last saw her alive on August 7, 1930 and that death occurred, on the date stated above, at 10.30 p.m.

The CAUSE OF DEATH* was as follows:

Chr. cardio-vascular disease

(duration) ✓ yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Hemiplegia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) A. Edmund Levine, M. D.

7/7. 1930 (Address) Levindale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel Rd

DATE OF BURIAL: 7/8 1930

UNDERTAKER: Sol Levinson & Bro

ADDRESS 1127 E Balto

c.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

59623 E 59623

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1. PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Baltimore City Hospitals

TY OF BALTIMORE: (NO. ST., WARD)

2. FULL NAME James Crew

(a) RESIDENCE NO. 1536 Division ST., 4-20 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

ATE OF BIRTH (month, day, and year) Jan. 1, 1874

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	7	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brickmaker

(b) General nature of industry, business, or establishment in which employed (or employer) Yd

(c) Name of employer

IRTHPLACE (city or town) Balto. (State or country) Md.

10 NAME OF FATHER Richard

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Nixon

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

Informant Records of (Address) Balto. City Hosp.

Filed 1930 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5-30

17 I HEREBY CERTIFY, That I attended deceased from 7-18-30, 19..., to 8-5-30, 19..., that I last saw him alive on 8-5-30, 19..., and that death occurred, on the date stated above, at 11:59 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

8-7-1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct

DATE OF BURIAL Aug 10 1930

20 UNDERTAKER C. L. Brown & Son

ADDRESS 109 W Monument St

...c.—1-30—M. & T.—250 Blks.

59624

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 E 59624

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

...TY OF BALTIMORE: (No. University Hospital ST., WARD) 4-30

2-FULL NAME Andrew Repko

(a) RESIDENCE NO. Middle River ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. 1 ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of or ~~WIFE~~ of Mary Repko

...DATE OF BIRTH (month, day, and year) Not Known

...GE Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
69	0	6	

...OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

...IRTHPLACE (city or town) (State or country) Austria

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

Informant Anna Repko

(Address) Latrobe, Pa.

...Filed 1930 H. A. Price JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4, 1930

17

I HEREBY CERTIFY, That I attended deceased from Aug. 3-1930, 19..., to Aug 4, 1930, 19...,

that I last saw him alive on Aug 4, 1930, 19...,

and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis

Hypertension, secondary.

Arteriosclerosis, generalized

(duration) 3 yrs. ? mos ds.

CONTRIBUTORY (Secondary) Uremia; Pneumonia

(duration) ? yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Phys. signs, symptoms + autopsy findings

(Signed) L. F. Hornbaker M. D.

8/7, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Latrobe Pa	8/9 1930
20 UNDERTAKER W. A. Saylor & Co.	ADDRESS 1618 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

59625

HEALTH DEPARTMENT—CITY OF BALTIMORE E 59625

CERTIFICATE OF DEATH. 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1234 W. Pratt ST., 18-29 WARD)

2-FULL NAME Baby Girl Cave

(a) RESIDENCE NO. 1234 W. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Robert M. G. Cave

11 BIRTHPLACE OF FATHER (city or town) Winchester, Va (State or country)

12 MAIDEN NAME OF MOTHER Mildred L. Cave

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant 1234 W. Pratt St (Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 2 P.M. 1930, to Aug 5 4 P.M. 1930,

that I last saw her alive on Aug 5, 1930,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Premature birth 30 wks

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis A. Hodgson M. D.

Aug 6. 1930 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

AUG 6 - 1930

Commissioner Health.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59626 ✓

E 59626

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1729 Laurens St ST., WARD) 16-22

2-FULL NAME Baby Girl Hawkins

(a) RESIDENCE NO. 1729 Laurens ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ~~7/24/28~~ 8/1/30

7 AGE — Years: — Months: — Days: 4 2 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Richard Hawkins

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Conquest

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant (Address)

15 Filed Aug 8 1930 H. LLOYD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Aug 3, 1930.

That I last saw her alive on Aug 3, 1930,

and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History & Physical

(Signed) Frank H. Kenyon M. D.

Aug 8 1930 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL: AUG 1930

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health.

rec.—1 12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59627 ✓ E 59627

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. W. Balt. Gen. Hosp ST., 8-12 WARD)

2-FULL NAME Helen Root

(a) RESIDENCE NO. 2507 E. Preston ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Barton P. Root.

DATE OF BIRTH (month, day, and year) Oct. 19th 1906

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	9	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home.

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Fairbanks Md.

10 NAME OF FATHER Thos. G. Parker

11 BIRTHPLACE OF FATHER (city or town) Worchester Co. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ella Bozman

13 BIRTHPLACE OF MOTHER (city or town) Somerset County
(State or country)

Informant Barton P. Root Husband
(Address) 2507 E. Preston St.

Filed 8 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/8/30 19

17 I HEREBY CERTIFY, That I attended deceased from 7/17/30, 19 ..., to 8/8/30, 19 ...,
that I last saw her alive on 8/8/30, 19 ...,
and that death occurred, on the date stated above, at 4:20 A. m.

The CAUSE OF DEATH* was as follows:

Pelvic abscess (Colon B)

over

(duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) coronary embolus

(duration) ... yrs. ... mos. 1 hr

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 7/15/30

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) W. Balt. Gen. Hosp., M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md. C. Church South Cemetery Fairbanks Md.

DATE OF BURIAL Aug 10th 1930

20 UNDERTAKER Lidy & Zeller Inc.

ADDRESS 603 S. Wolfe St

c.—1-30—M. & T.—250 Blks

E 59628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 59628

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

ITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Charles McKinley

(a) RESIDENCE NO. 927 Gorsuch ave. 9-46 ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Sept. 2, 1909

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	11	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Elias McKinley

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Emma Hotz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

Informant Hospital Records
(Address)

Filed 8- 1930 C. H. Blanchard JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to Aug. 7, 1930, that I last saw him alive on Aug. 7, 1930, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Tenner, M. D.

8-7, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemet

DATE OF BURIAL Aug 9 1930

20 UNDERTAKER W M Routzahn

ADDRESS 223 E Fay

Type.—6 9-19—H. P. Co.—1060 Blks.

Coleman

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59629

CERTIFICATE OF DEATH. 161-00

E 59629

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 Park ST.: 11th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Coleman

(a) RESIDENCE. NO. 1033 Park ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year): 7-30-30

8 AGE: Years ..... Months ..... Days 8 7 If LESS than 1 day, ... hrs. or ..... min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): 1033 Park

11 NAME OF FATHER: Rudolph Coleman

12 BIRTHPLACE OF FATHER (city or town) (State or country): Va

13 MAIDEN NAME OF MOTHER: Ruth Jackson

14 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 7 1930

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1930, to Aug 5, 1930

that I last saw h.. alive on Aug 5, 1930

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Premature birth

6½ fetal month

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A H Pearce M. D.

Aug 8, 1930 (Address) 205 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: C. Hampson Jones, M. D.

ADDRESS

Filed AUG 8 - 1930

Registrar

Commissioner Health.

AUG 8 - 1930

e.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59630

E 59630

CERTIFICATE OF DEATH

11-24-43

REGISTERED NO.

1—PLACE OF DEATH

TY OF BALTIMORE: (No. Maryland Gen. Hosp. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Joseph Hutchinson X

(a) RESIDENCE NO. Harborton Va. WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. 1 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Hutchinson

ATE OF BIRTH (month, day, and year): July 27-1865

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65	4	0	11	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

IRTHPLACE (city or town) State or country: Virginia

10 NAME OF FATHER: James Hutchinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Miss Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

Informa: Maryland Gen. Hosp.

(Address)

Fi 1930 19 THOMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-8-1930

17

I HEREBY CERTIFY, That I attended deceased from 8-5, 1930, to 8-8, 1930, that I last saw h alive on 8-8-, 1930 and that death occurred, on the date stated above, at 10 45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue with metastasis to neck involving carotid sheath

Appx (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8-6 30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert V. Clements, M. D.

19 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harborton Va.

DATE OF BURIAL: 8/10 1930

UNDERTAKER: J. Few McCully

ADDRESS: 130 E. Fort.

Spec—12-23-21—E.B.R.S.—400 Blks.

E 59631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 38

E 59631

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4 S 19 Eastern Av St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mary Karedes

(a) Residence No. 4 S 19 Eastern St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.)

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 8/7/30

7-AGE. yrs. mos. 1 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) 4 S 19 Eastern Av (State or Country),

PARENTS.

10-NAME OF FATHER Leo Karedes.

11-BIRTHPLACE OF FATHER (city or town) Greece. (State or Country),

12-MAIDEN NAME OF MOTHER Kalopsa Karedes,

13-BIRTHPLACE OF MOTHER (city or town) Greece (State or Country).

14-INFORMANT Father

(Address) 4 S 19 Eastern Av

15-FILED 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/7/30

17- I HEREBY CERTIFY, That I attended deceased from Aug 7, 1930 to Aug 8, 1930, that I last saw h- alive on 8/7/30, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Premature

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Twins

Duration yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Wm Greenbaum M. D.

8/8 1930 (Address) 4 S 3 Eastern Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cem. DATE OF BURIAL. 8/9/30

20-UNDERTAKER. Geo. J. Ruth & Son ADDRESS 1735 Hoffman St

...—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59632

CERTIFICATE OF DEATH

90 E. 59632

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 4204 Belmar Ave. ST. 27.44 WARD)

2—FULL NAME Elizabeth Gebhardt Michel

(a) RESIDENCE NO. 4204 Belmar Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
emale	White	Widow

f married, widowed, or divorced HUSBAND of (or) WIFE of J. J. Michel

ATE OF BIRTH (month, day, and year) Dec. 13, 1850.

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	7	23 24	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Germany

0 NAME OF FATHER Christian Gebhardt

1 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

2 MAIDEN NAME OF MOTHER Elizabeth Wolf

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. John Sendelbach

(Address) 4204 Belmar Ave.

Filed C. HAMPSON JONES, M. D. Registrar

1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 7/30.

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1928, to aug 7, 1930, that I last saw h[illegible] alive on aug 7, 1930 and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic
Acute dilatation Heart

Arteriosclerosis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertention (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert G. Webster, M. D.

8/8, 1930 (Address) 6409 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery,	Aug. 9, 1930.
20 UNDERTAKER	ADDRESS
Wm. L. Black	927 N. Broadway

...—1-30—M. & T.—250 Blks.

59633

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59633

CERTIFICATE OF DEATH.

194

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 274 S. Monastery Ave, 20-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda M. Hibaley

(a) RESIDENCE NO. 274 S. Monastery Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

If married, widowed, or divorced HUSBAND of or) WIFE of Wiliegin Hibaley

DATE OF BIRTH (month, day, and year) Nov 26, 1843

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
87	85	4	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (City or town) (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Unknown

Informant Mrs. Lulya A. Mosley

(Address) 274 S. Monastery Ave

Filed C. HAMPSON JONES, M. D. Registrar

1930 Dec

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8, 1930

17

I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930, to Aug 8, 1930

that I last saw h[illegible] alive on Aug 8, 1930

and that death occurred, on the date stated above, at 3:30 P.M. E.S.T.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis and Heat Prostration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. M. Nelson M. D.

, 19 (Address) 848 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug. 11, 1930
20 UNDERTAKER	ADDRESS
Easton Lowe	Ellicott City

Spec.—1-10-21—M&T—1500 Bks.

E 59634

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59634

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 900 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Edward Dorney

(a) RESIDENCE NO. 442 Millington Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara B. Dorney

6 DATE OF BIRTH (month, day, and year): Jan. 29. 1876

7 AGE: Years 54 Months 6 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hand Drill Press

(b) General nature of industry, business, or establishment in which employed (or employer): Standard Gas. Eqipt

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co. Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mr Edward Dorney 442 Millington Lane

15 Filed 1930, 19 HARRISON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-8 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-13, 1930, to 8-8, 1930, that I last saw him alive on 8-8, 1930, and that death occurred, on the date stated above, at 10.15 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of hip bone

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Anaemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 3-15-30

Was there an autopsy? No

What test confirmed diagnosis? Frozen Section

(Signed) H. Lyman S. Anderson M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Aug 11 1930

20 UNDERTAKER: Mr-Mrs. John W. Teufel & Son — ADDRESS: 801 W Fayette

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59635

CERTIFICATE OF DEATH

1941 E 59635

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 59635

1-PLACE OF DEATH

City of Baltimore: (No. 418 N. Pine St., 17-16 Ward)

2-FULL NAME Porter Washington

(a) RESIDENCE NO. 418 N. Pine St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Frances Washington

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Frances Washington
(Address) 418 N Pine St

15 Filed ..... C. HAMPSON JONES, M. D.
Registrar
By ANA
8 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Prostration

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D.

8/8. 1930 (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 8-9 1930

20 UNDERTAKER Daniel Gorton

ADDRESS 916 Pac

c.—1-30—M. & T.—250 Blks.

Dr Raitzel 2221 Fulton Ave Zal 3620

E 59636 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 920 N. Appleton ST. 16-22 WARD)

REGISTERED NO. 94 E 59636

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie D. Franklin

(a) RESIDENCE NO. 920 N. Appleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

8 to Burleigh

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If ~~married~~, widowed, ~~or divorced~~ HUSBAND of or) WIFE of Rezin N. Franklin

DATE OF BIRTH (month, day, and year) March 25th 1851

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	4	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

BIRTHPLACE (city or town) Pokes Springs

(State or country) Howard Co Md

10 NAME OF FATHER Perry G. Puckett

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Rachel Tucker

13 BIRTHPLACE OF MOTHER (city or town) Howard Co

(State or country) Md

Informant Annie M. Patterson

(Address) 920 N. Appleton St

Filed ..... 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 - 1930

17 I HEREBY CERTIFY, That I attended deceased from June 4th, 1930, to Aug. 8th, 1930, that I last saw her alive on Aug. 7th, 1930, and that death occurred, on the date stated above, at 8:40 A. m.

The CAUSE OF DEATH* was as follows:

Uremic Retention

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Disease

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Routine

(Signed) Ezbulle C. Raitzel M. D.

8/8, 1930 (Address) 2221 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Morgan Chapel Cem Woodbine Md

DATE OF BURIAL 8/10/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 A Pulaski

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59637

CERTIFICATE OF DEATH

90 / E 59637

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 1446 Patapsco St. 23-33 (Ward)

2-FULL NAME Nelson O'Neil Robosson.

(a) RESIDENCE NO. 1446 Patapsco St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 4 mos. 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed~~ HUSBAND of ~~WIFE~~ Mary Robosson.

6 DATE OF BIRTH (month, day, and year) March 26, 1853

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	77	4	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) B.& O.R.R.Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Mary Thompson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Mary Robosson. (wife)
(Address) 1446 Patapsco St.

15 Filed ..., 19.. C. HAMPTON JONES M. D. Registrar
9-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis.
Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY
(Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible], M. D.

8/7, 1930 (Address) 1019 E. Charles St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Aug 9 1930
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

30—M. & T.—100 B—50L

E 59638

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59638

CERTIFICATE OF DEATH

REGISTERED NO. 11

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 4514 Arabia ST., 27-47 WARD)

2-FULL NAME Franz Fuchs

(a) RESIDENCE NO 4514 Arabia Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of the late Louisa C. Fuchs

7 DATE OF BIRTH (month, day, and year) Dec 11th 1846

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	7	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

10 NAME OF FATHER F. Fuchs

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant John H. Schaefer

(Address) 4514 Arabia ave

15 1930 ..... 192 ..... Registrar

HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Duration Chr. Gastritis ulcer. yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chr. Gastritis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Phy. History

(Signed) H. C. Wades, M. D. Coroner

, 19 (Address) 143 N Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Aug 9. 1930

20 UNDERTAKER Geo C. Miller & Son

ADDRESS 2334 Jefferson

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 59639

REGISTERED NO. E 59639

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1114 Montpelier St, St. (4-46 Ward)

2-FULL NAME James E. Connor

(a) RESIDENCE NO. 1114 Montpelier St. St., Ward

(Usual place of abode) Lifetime (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Christina Connor

6 DATE OF BIRTH (month, day, and year) June 28th. 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	56	1	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shipping Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Matthew Connor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant (Address) Mrs. Christina Connor. 1114 Montpelier St.

15 Filed ....., 19.... Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8th. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 3 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Broken Compensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What tests confirmed diagnosis? By History

(Signed) C. O. Gladding, M. D.

, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 8/11 1930

20 UNDERTAKER Chas. P. Ford & Son

ADDRESS 11 W. Mt. Royal Ave

c.—1-30—M. & T.—250 Blks.

E 59640 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59640

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph's Hospital — REGISTERED NO. 17
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Calvert St. (Ward)

2-FULL NAME Philomena D. Geil

(a) RESIDENCE NO. 3516 Dipton St AVE WARD
(Usual place of abode) (If non-resident give City or town and State)

Length of residence in city or town where death occurred 41 yrs. — mos. 29 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
Husband of or) WIFE of John J. Geil.

DATE OF BIRTH (month, day, and year) July 8 1889

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	—	29	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Michael Pultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Louisa J. Kinlein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

Informant Mr. John J. Geil
(Address) 3516 Dipton Ave

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7/30

17 I HEREBY CERTIFY, That I attended deceased from 7-16-30, 19..., to 8-7-30, 19...,
that I last saw h.. alive on 8-7-30, 19...
and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Appendicitis Abscess
(duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary) Pneumonia
(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? Yes Date of 8-7-30
Was there an autopsy? No
What test confirmed diagnosis? Operation

(Signed) M. Eleanor M. D.
8/7/1930 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Aug. 11th 1930

20 UNDERTAKER Henry Hoeck Sons Inc. — ADDRESS 1201 E Eager St

...c.—1-30—M. & T.—250 Blks.

E 39364 8 E 39641

HEALTH DEPARTMENT—CITY OF BALTIMORE E 59641

CERTIFICATE OF DEATH.

+ 21-001

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

...TY OF BALTIMORE: (No. ... ST., 29 WARD)

2-FULL NAME Herbert Merrath

(a) RESIDENCE NO. 25 N. Wright Ave ST., ... WARD Phila. Pa. (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 10 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) August 1st 1898

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	0	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

BIRTHPLACE (city or town) Philadelphia Pa (State or country)

10 NAME OF FATHER Charles Merath

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Caroline Fiser

13 BIRTHPLACE OF MOTHER (city or town) Penn (State or country)

Informant Friends

(Address) Johns Hopkins Hospital

Filed ... 19 1930 ... 19 ...

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8-30

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1930, to Aug 8, 1930, that I last saw him alive on Aug 8, 1930, and that death occurred, on the date stated above, at 3 20 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis

over

(duration) ... yrs. ... mos 3 da.

CONTRIBUTORY (Secondary) none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ... Disease contracted at Morocco for Meningitis

Did an operation precede death? yes Date of 8-3-30

Was there an autopsy? yes

What test confirmed diagnosis? Bacteriological report.

(Signed) Fred W Bell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa

DATE OF BURIAL Aug 11th 1930

UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument St

Spec.—7-17-26—A Co.—200 Blks.

E 59642

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 VE 59642

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 7 S Fulton Ave St. 14-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia L. Thompson

(a) RESIDENCE NO. 15 Fulton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dallas E Thompson

6 DATE OF BIRTH (month, day, and year) 9-30 1889

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
40	39	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in whirh employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) N. C.

(State or country)

PARENTS

10 NAME OF FATHER John L Mitchell

11 BIRTHPLACE OF FATHER (City or town)

(State or country) N.C.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

14 Informant Dallas E Thompson

(Address) 7 S. Fulton Ave

15 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7 1930

17 I HEREBY CERTIFY, That I attended deceased from 8/5, 1930, to 8/7, 1930, that I last saw her alive on 8/7, 1930, and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Carcinoma, Ovary

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs.

(Signed) Sidney H. Streett M. D.

8/8. 1930 (Address) 450 E. Fayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

Date of Burial Aug. 9 1930

UNDERTAKER C. Jones

ADDRESS N. Ave

Cor.—10-10-29—A Co.—100 Bks.

E.5 9643

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1930 E.5 9643

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH City of Baltimore: (No. W. Balto Gen Hosp St. 15-21 Ward)

2-FULL NAME Starkey E. Redgley

(a) RESIDENCE NO. 1618 N. Monroe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-26-1914

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	15	7	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Marshall W Redgley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elsie May Pletz

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Md

14 Informant Marshall W Redgley (Address) 1618 N Monroe St

15 Filed ....., 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: While on pavement auto beyond control struck her knocking her down resulting in (19) Fract. Skull. Mult. Fract Ribs

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E. Strauss, M. D.

July 30, 1930 (Address) 1939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	Aug 11 1930

20 UNDERTAKER Joseph Sefer Hoo W North St ADDRESS

...c.—1-30—M. & T.—200 Blks.

E 59644

3939 47
N. Surg.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X74-001

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

...ITY OF BALTIMORE, (NO. ..... ST. 79 WARD)

2-FULL NAME Ralph W. Eby

(a) RESIDENCE NO. Lancaster, Pa. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 4 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
Male	White	Married

If married, ~~widowed, or divorced~~ HUSBAND of or) WIFE of Caroline Eby

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Executive

(b) General nature of industry, business, or establishment in which employed (or employer) Seed business

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pa.

10 NAME OF FATHER Milton Eby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Alice Eckman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

Informant (Address) Records JOHNS HOPKINS HOSP.

Filed ... 19 1930 ... S. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930, to Aug 8, 1930, that I last saw ~~him~~ alive on Aug 8, 1930, and that death occurred, on the date stated above, at 10.25 P. m.

The CAUSE OF DEATH* was as follows:

- Epidermoid hemorrhage
? Brain tumor

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8-5-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) C. H. Brigg, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Paradise, Penna.

DATE OF BURIAL Aug 9 1930

20 UNDERTAKER John D. Mitchell & Son

ADDRESS 1911 Eutaw Pl.

Spec.—1-10-21—M&T—1500 Blks.

E 59645

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59645

CERTIFICATE OF DEATH.

REGISTERED NO. 161-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hosp (Street) 21-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Smith

(a) RESIDENCE NO. 718 Dover St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-30-30

7 AGE: Years | Months | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Henry Daily

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Helen Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Mother - Helen Smith 718 Dover St

19 8-1930, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-2 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-1-30, 1930, to 8-2, 1930,

that I last saw her alive on 8-1, 1930,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

Hemorrhage & Atelectasis of Newborn

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis H. Douglass M. D.

8/7 1930 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: AUG 8 - 1930

20 UNDERTAKER

ADDRESS

BAYSON JONES, M. D. Commissioner Health

1 PLACE OF DEATH

County E 59646

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. E 59646

Village or City Baltimore (No. 2806 Bernard St.) (Ward) 24-51

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	single

6 DATE OF BIRTH: aug (Month) 7 (Day), 1930 (Year)

7 AGE: ... yrs. ... mos. ... ds. If LESS than 1 day 9½ hrs. or ... min. ?

8 OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry business, or establishment in which employed or (employer):

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Lyle Carter Chandler

11 BIRTHPLACE OF FATHER (State or country): South Dakota

12 MAIDEN NAME OF MOTHER: Margaret May Gower

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lyle C Chandler
(Address) 2806 Bernard St Balto

15 Aug - 1930 C. HAMPSON JONES, M. D. Registrar
By ...
(Date received by local registrar) (Signature and address State Registrar. 16 W. Mulberry St., Balto., Requesting V. S. No. 1

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: aug (Month) 8 (Day), 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from aug 7 1930, to aug 8, 1930, that I last saw him alive on aug 7, 1930, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH * was as follows:

Premature Birth

9½ hrs.
(Duration) ... yrs. ... mos. ... da.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... da.

(Signed) B R Benson Jr M. D.
aug 8 1930 (Address) Cockeysville Md

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ... yrs. ... mos. ... da. In the State, ... yrs. ... mos. ... da.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: HOPKINS Parish

DATE OF BURIAL: ..., 19...

20 UNDERTAKER: Commissioner Health.

ADDRESS: AUG 9 - 1930

E. WOODALL

...c.—1-30—M. & T.—250 Blks.

39481
Red
E 59647

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 01
E 59647

CERTIFICATE OF DEATH.

X 16

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 7-9 ST. WARD)

2-FULL NAME Baby Pearce

(a) RESIDENCE NO. Belair, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) July 30, 1930.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Maryland
(State or country)

10 NAME OF FATHER Arthur Pearce

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mamie Gunther

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

Informant Records
(Address) JOHNS HOPKINS HOSPITAL

Filed AUG 9 1930, 19
By C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-4-30

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Aug 4, 1930,
that I last saw him alive on Aug 4, 1930,
and that death occurred, on the date stated above, at 10 55 p. m.

The CAUSE OF DEATH* was as follows:

prematurity

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. C. Geo Irvin, M. D.

8-, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
JOHNS HOPKINS HOSPITAL

DATE OF BURIAL
19

20 UNDERTAKER

ADDRESS

Commissioner Health.

AUG 9 - 1930

30—M. & T.—100 B—50L

E 59648

HEALTH DEPARTMENT—CITY OF BALTIMORE

168 ✓ E 59648

CERTIFICATE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 364 Mt Olivet Lane ST. 20-7 WARD)

2-FULL NAME Jno. W. Reinhold

(a) RESIDENCE NO 364 Mt. Olivet Lane ST.... WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Rein

DATE OF BIRTH (month, day, and year) May 19th 1866

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	2	19	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shipping Clerk at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

009

BIRTHPLACE (city or town) Md
(State or country)

10 NAME OF FATHER Conrad Reinhold

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

Informant Amelia Reinhold

(Address) 364 Mt Olivet Lane

Filed 1930 192 G. HAMPSON JONES, M. D. Registrar

AFH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/8/30 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to L death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide - by Gunshot
at home
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. W. Brooks, M. D.
Coroner

8/8, 1930 (Address) Brooklyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cem.

DATE OF BURIAL Aug 11th 1930

20 UNDERTAKER Chas. W. Dill.

ADDRESS 3109 Fredk Ave.

c.—1-30—M. & T.—250 Blks

E 59649 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59649

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. President Hospital St. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Brooks Talbott

(a) RESIDENCE NO. Catonsville Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

If married, widowed, or divorced HUSBAND of or) WIFE of —

DATE OF BIRTH (month, day, and year) Mar. 9, 1930

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	29 30	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Catonsville

(State or country) Md

10 NAME OF FATHER Theodore Talbott

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ada Brooks

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

Informant Mrs. Ida Brooks

(Address) Catonsville Md

Filed 0 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-8-30

17

I HEREBY CERTIFY, That I attended deceased from July 11, 1930, to Aug 8, 1930,

that I last saw him alive on Aug 8, 1930,

and that death occurred, on the date stated above, at 11 45 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Malnutrition Debydration

Bronchitis (duration) yrs. mos. 2 5 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Conrad McClean, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harris Family Cem

DATE OF BURIAL Aug 10 30

20 UNDERTAKER Easton Sons

ADDRESS Ellicott City

59650 HEALTH DEPARTMENT—CITY OF BALTIMORE 59650

CERTIFICATE OF DEATH. REGISTERED NO. C

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. Mercy Hospital WARD)

2-FULL NAME John Sellers Barnes St.; yrs., mos. 1 ds.)

(Residence in Baltimore: No. Gibson Islands

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 30 (Day) 1881 (Year)

7-AGE. 49 yrs. 2 mos. 9 ds. If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer)

PARENTS:

9-BIRTHPLACE, (State or Country), Phila Pa

10-NAME OF FATHER, George Taylor Barnes

11-BIRTHPLACE OF FATHER (State or Country), Phila Pa

12-MAIDEN NAME OF MOTHER Lusie Sellers

13-BIRTHPLACE OF MOTHER (State or Country), Phila Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Geraldine S Barnes

(Address) Gibson Islands

15- Filed AUG 10 1930, 191.... C. HAMPSON JONES, M.D. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 9 (Month) (Day) 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

Duration ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

Duration ....yrs....mos....ds.

(Signed) W. T. Riley M. D. (Coroner.)

Aug. 9, 1930 (Address) 10 S. Gay Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Phila Pa DATE OF BURIAL, Aug 10, 1930

20-UNDERTAKER Henry Jenkins & Co ADDRESS Eutaw & Lafayette

ec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59651

CERTIFICATE OF DEATH.

57 E 59651

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida Wilson

(a) RESIDENCE NO. 5223 Florence Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Levin F. Wilson

DATE OF BIRTH (month, day, and year) Nov 28th 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	8	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Delaware

10 NAME OF FATHER Jas. Bury Pearce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Lavinia Hastings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

Informant Levin Wilson

(Address) 5223 Florence Ave

Filed AUG 12 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930, to Aug 9, 1930, that I last saw her alive on Aug 9, 1930, and that death occurred, on the date stated above, at 12:55 p m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Fractured Left Scapula (8-12-30)

Fracture 7th, 8th, 9th ribs (right side)

acc. fall down steps at her home (duration) yrs mos ds.

CONTRIBUTORY Broncho-pneumonia

(Secondary) (duration) yrs. mos. 2 ds.

18 Where did disease contracted if not at place of death? At home

Did operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

Signed T. Johnson, M. D.

19 (Address) W. Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 8/12 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

c.—1-30—M. & T.—250 Bks.

E 59652

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59652

CERTIFICATE OF DEATH.

94-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

ITY OF BALTIMORE: (No.) Esplanade Apts. 2 D. ST. 13-54 (WARD)

2-FULL NAME Emelia Schiff

(a) RESIDENCE NO. Esplanade Apts. 2 D. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
or) WIFE of

ATE OF BIRTH (month, day, and year) Dec. 10th. 1862

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	29	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER Meyer Schiff

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Bible Records.
(Address)

0 1930 [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9th. 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1927, to Aug. 9, 1930,
that I last saw her alive on Aug 8, 1930,
and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage-

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis - Hypertension

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual - Laboratory Test

(Signed) Joseph W. Kelly, M. D.

19 (Address) 1207 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem.

DATE OF BURIAL 8/10/ 1930

20 UNDERTAKER David Sondheim & Son

ADDRESS 1902 Eutaw Place

c.—1-30—M. & T.—250 Blks.

59653 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 72E 59653

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home & Infirmary ST., (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Graffin Cook

(a) RESIDENCE NO. 3301 N. Charles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 8 mos. 23 ds. How long in U. S., if of foreign birth? 59 yrs. 8 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte Mallory Cook

DATE OF BIRTH (month, day, and year) Nov-17-1870

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	8	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer none

BIRTHPLACE (city or town) Balto.
(State or country) Md.

10 NAME OF FATHER Saml G. B. Cook

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ludlow

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

Informant Mrs Charlotte M. Cook - (wife)
(Address) Same as 33 St.

FILED AUG 10 1930 19 G. HOWARD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1930 to Aug 9, 1930, that I last saw him alive on Aug 9, 1930, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Fatal Coronary Thrombosis

(duration) 5 or more yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon H. Norwood, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emerald Hill Cemetery DATE OF BURIAL Aug. 12, 30

UNDERTAKER Stewart Memorial Co ADDRESS Baltimore

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59654 | 194 E 59651 | REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 2 1 Sinai Hospital St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Jacobs

(a) RESIDENCE NO. 2219 Orleans St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 22, 1902

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	28	6	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Nurse
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Morris Jacobs

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Lena Krauss

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Mrs. Lena Jacobs (Mother)
(Address) 2210 Orleans St.,

15 Filed ... 19... [illegible] Registrar

1930 C. [illegible] JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8th-1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Heat Stroke

(duration) yrs. 3 hrs. ds.

CONTRIBUTORY (Secondary) Collapse

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

(Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt. Carmel

DATE OF BURIAL 8-10- 1930

20 UNDERTAKER Jack Levin, 1439

ADDRESS [illegible]

c.—1-30—M. & T.—250 Bks.

E 59655 HEALTH DEPARTMENT—CITY OF BALTIMORE, MD. E 59655

CERTIFICATE OF DEATH.

REGISTERED NO. 111

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Sinai Hospital ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Kutzman

(a) RESIDENCE NO. 210 r Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

If married, widowed, or divorced HUSBAND of or) WIFE of Malkie Kutzman

DATE OF BIRTH (month, day, and year) Nov. 18-1870

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	8	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant (Address) J. Lewis 1439 E. Baltimore St

C. H. JONES, M. D. Registrar

FILED 10 1936

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9/30.

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to Aug 9, 1930, that I last saw him alive on Aug 9th, 1930, and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

gastric ulcer with cicatrization and pyloric obstruction.

(duration) 3 yrs. mos da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? yes Date of Aug. 7, 1930

Was there an autopsy? yes.

What test confirmed diagnosis? Physical findings

(Signed) W. A. Coker, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sinai Rosedale — DATE OF BURIAL 8-10-1930

20 UNDERTAKER Jack Lewis, 1439 E Balto. St — ADDRESS

c.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

59656 E 59656

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 2 ST., 10-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennis Wall

(a) RESIDENCE NO. Sisters of Poor. Preston & Valley Sts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. dy. How long in U. S., if of foreign birth? yrs. mos. dy.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 22 (?) 1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	6 16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer) 056

(c) Name of employer

BIRTHPLACE (city or town) (State or country) N.Y.

10 NAME OF FATHER John Wall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Carrol

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Hospital Records

(Address)

0-1939 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8/30.

17 I HEREBY CERTIFY, That I attended deceased from 8-6, 1930, to 8-8, 1930, that I last saw him alive on 8-8, 1930, and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia (inguinal)

(duration) yrs. mos dy.

CONTRIBUTORY (Secondary) Stricture of rectum Intussusception

(duration) yrs. mos. dy.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 8-8-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical & operative

(Signed) J. Leyko, M. D.

8/8, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Aug. 11, 1930

ADDRESS

20 UNDERTAKER Rider Neudefeld 914 Greenmount Ave

c.—1-30—M. & T.—250 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59657

CERTIFICATE OF DEATH.

76

E 59657

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 4906 Belair Road ST. 27-41 WARD

2-FULL NAME Katie Glowman

(a) RESIDENCE NO. 4906 Belair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
HUSBAND of (or) WIFE of James Robert Glowman

DATE OF BIRTH (month, day, and year) July 8th 1878

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	1	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John Kiegtel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Katie Krapf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

Informant James Robert Glowman

(Address) 4906 Belair Road

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from ....., 1928, to Aug 9, 1930,

that I last saw her alive on Aug 8th, 1930,

and that death occurred, on the date stated above, at 5.30 a. m. Standard

The CAUSE OF DEATH* was as follows:

Cancer

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gunther & Fry, M. D.

8/9, 1930 (Address) Arcade

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 8/11/1930

ADDRESS

20 UNDERTAKER Geo. Weber & Son 2503 Edmondson

AUG 1930

ee.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59658

CERTIFICATE OF DEATH.

129 E 59658

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1919 E Lombard St 7th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Thelma Arnold

(a) RESIDENCE NO. 1919 E Lombard St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Arnold

DATE OF BIRTH (month, day, and year) April 23 1910

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	20	3	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Martin Englehardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Lucie Yeager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

Informant Thomas Arnold

(Address) 1919 E Lombard St

Filed AUG 10 1930 19 R K JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1930

17 I HEREBY CERTIFY, That I attended deceased from July 29" 1930, to August 10 1930,

that I last saw her alive on August 9 1930

and that death occurred, on the date stated above, at 2 A m

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb N Athey, M. D.

Aug 10 1930 (Address) 100 S. Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: Aug 13 1930

20 UNDERTAKER: Martin W. C. Diffenbaugh

ADDRESS: 3 E Lanvale

...c.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59659

CERTIFICATE OF DEATH.

74

E 59659

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3103 Mary Ave. ST. 27-43 (WARD)

2-FULL NAME Mary S. Miller

(a) RESIDENCE NO. 3103 Mary Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Late John Miller

DATE OF BIRTH (month, day, and year) Sept. 11, 1846.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	10	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER William Blaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julie Street

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Mrs. Grace Miller,

(Address) 3103 Mary Ave. Hamilton

FILED AUG 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8. 30

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Aug 8, 1930,

that I last saw her alive on Aug 8, 1930,

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

Senility

(Duration) yrs. mos da.

CONTRIBUTORY (Secondary) Hypertension

(duration) unk ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. E. Richardson, M.D.

Aug 10 1930 (Address) 112 W. 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel Cem. Harford Co. Md.

DATE OF BURIAL 8/11/30

20 UNDERTAKER Harry N. Wittlee #101

ADDRESS Edmondson Ave.

c.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59660

CERTIFICATE OF DEATH.

47 E 59660

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 422 S. Parish ST., 19-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice M. Benton

(a) RESIDENCE NO. 422 S. Parish ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced (or) WIFE of Charles F. Benton

DATE OF BIRTH (month, day, and year) Nov 16-1872

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	8	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Snow Hill Md

10 NAME OF FATHER John Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Charles F. Benton

(Address) 422 S. Parish

Filed ..... 19 ..... Registrar

D 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7th 30

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to Aug 7th, 1930, that I last saw h alive on Aug 7th 1930, and that death occurred, on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Carcinoma of the breast

(duration) one yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? Yes Date of Aug 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical & microscopical

(Signed) Wm Hamilton, M. D.

8/8, 1930 (Address) 1701 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Salem Cem. Wilmington Del.

DATE OF BURIAL 8/11/30

20 UNDERTAKER Harry H. Witzke

ADDRESS 410 Edmondson Ave.

G. H. Roper JONES, M. D.

—M. & T.—250 Blks.

E 59661 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59661

49

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 14-28 WARD)

2-FULL NAME George Pearl

(a) RESIDENCE NO. 119 S. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) March 6, 1875

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	5	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pumping Sta.

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer City of Balto. 8/6

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Samuel T. Pearl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah E. Colburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mrs. Edw E. Stivers

(Address) 119 S. Gilmor St

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug. 9-1930

17

I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to Aug. 9 1930,

that I last saw him alive on Aug 9, 1930,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, abdominal (Primary source undetermined)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema; myocardial insufficiency (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Phys. signs, symptoms, autopsy findings.

(Signed) H. H. Homebaker M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL 8/12 1930

20 UNDERTAKER Harry H. Mutzke 4101

ADDRESS Edmondson Ave.

Dec.—1-12-23—M&T—500 Blks.

59662

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59662

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 416 E 25th St

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) S. 17-50 WARD)

2-FULL NAME Lily Loretta Cummings

(a) RESIDENCE NO. 416 E 25th ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) July 4, 1893

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	0	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) New York
(State or country) N. Y.

10 NAME OF FATHER Lawrence W. Cummings

11 BIRTHPLACE OF FATHER (city or town) New York
(State or country) N. Y.

12 MAIDEN NAME OF MOTHER Mary A. Donahue

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

Informant Miss May E. Cummings
(Address) 416 E. 25th Street

Filed 8-1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8 1930

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1930, to August 8, 1930, that I last saw her alive on August 8, 1930 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

tuberculosis - pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) pulmonary tuberculosis

(duration) at least 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? laboratory & clinical methods

(Signed) Hawlett Smith Jr, M. D.

, 19 (Address) 927 N Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 8/11 1930

20 UNDERTAKER Henry W. Mears and Son

ADDRESS 805 N. Calvert

c.—1-30—M. & T.—250 Blks

9663

E 59663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 1352 57

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3413 Kenwick Rd. ST. 24 WARD)

2-FULL NAME William F. Henderson

(a) RESIDENCE No. 3413 Kenwick Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Alverta Henderson

DATE OF BIRTH (month, day, and year) Sept 16 1852

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	10	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) md.
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

Informant Mrs. John Walker
(Address) 3413 Kenwick Road

Filed AUG 10 1930 H. ... JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8, 1930

17

I HEREBY CERTIFY, That I attended deceased from Mar 24, 1930, to Aug 8, 1930,

that I last saw him alive on Aug 7, 1930,

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

arteriosclerosis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Cancer of bladder

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) [illegible], M. D.

Aug 9, 1930 (Address) 3417 Chesterfield Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

20 UNDERTAKER Chenowith Lee

DATE OF BURIAL Aug 11 1930

ADDRESS 3615 Chesterfield Ave

30—M. & T.—100 B—50L

E 59664

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1930 E 59664

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3217 Brookshire ST., 27-41 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Weinhold

(a) RESIDENCE NO. 3217 Brookshire ST., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of late Frank Weinhold

DATE OF BIRTH (month, day, and year) Aug 30th 1845

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	11	7	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs Robert Clark (Daughter)

(Address) 3217 Barkshire Road

Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fall down Stairs
Fracture of femur

(duration) 1 yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? By History

(Signed) G C Glades, M. D. Coroner

, 19 (Address) 1376 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

20 UNDERTAKER Lilly & Geiler Inc

DATE OF BURIAL Aug. 11th 1930

ADDRESS 403 S. Wolfe St

0 1930

ec.—1-30—M. & T.—250 Bks

E 59665 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 59665

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (NO. 18-N STREET) (WARD)

2-FULL NAME Frances Washington

(a) RESIDENCE NO. 312 N. Poppleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Centerville

(State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Liza Vaco

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

Informant Records of

(Address) Balto. City Hosp.

Filed 6 1930 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-9-30

17

I HEREBY CERTIFY, That I attended deceased from 7-30-30, 19..., to 8-9-30, 19...,

that I last saw her alive on 8-9-30, 19...,

and that death occurred, on the date stated above, at 8:15 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) UNKNOWN yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) UNKNOWN yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padgett., M. D.

8-9-1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Aug 11 1930

20 UNDERTAKER Dan'l Easton

ADDRESS 946 Bond

...—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 59666 | 129E 59666

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 345 Chesterfield Ave ST. 17-50 WARD)

2—FULL NAME Annie M. Kuehne

(a) RESIDENCE NO. 345 Chesterfield Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Kuehne

ATE OF BIRTH (month, day, and year) Jan 14 1869

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	6	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) retired

(c) Name of employer

BIRTHPLACE (city or town) Balto
(State or country) Md

10 NAME OF FATHER Joseph A Cruse

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Anna R Spellissy
Balto

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

Informant Mrs Edw J Kultenbach

(Address) 345 Chesterfield Ave

Filed AUG 1 19 30 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930, to Aug 8, 1930, that I last saw her alive on Aug 8, 1930 and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Nephritis - Arteriosclerosis (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys

(Signed) Wm Lee Stiller, M. D.

8/9, 1930 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Aug. 11- 1930

20 UNDERTAKER Margaret E. Flynn — ADDRESS 1417 Light St.

Spec.-7-17-26—A Co.—200 Blks.

E 59667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

41 E 59667

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1741 N. Carolina St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Rosalba Busey

(a) RESIDENCE NO. 1741 N. Caroline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Busey

6 DATE OF BIRTH (month, day, and year) March 17 1850

7 AGE	Years	Months	Days
	80	4	22

IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER George R. Rusk

11 BIRTHPLACE OF FATHER (City or town) Ohio

(State or country)

12 MAIDEN NAME OF MOTHER Alice Lane

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Mrs. Lily M. Rusk

(Address) 1741 N. Caroline St

OCT 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8 1930

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to August 8, 1930,

that I last saw h.. alive on August 8, 1930

and that death occurred, on the date stated above, at 5:50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the breast

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandbrook, M. D.

8 9. 1930 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Allen Mound Cem — Date of Burial Aug 11" 1930

20 UNDERTAKER Joseph B. Cook — ADDRESS 603 N. Gilmor St

ec.—1-30—M. & T.—250 Blks.

59668 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59668

90

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: (No.) Mount Hope Retreat ST. 28-63 (Bd.)

2-FULL NAME Adeline Shoemaker

(a) RESIDENCE NO. Mt Hope Retreat ST. 28 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
At	58	0	0	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machine Operator

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Town (?) Maryland

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Not Known

Informant (Address) Records of Mt Hope Retreat Mt Hope

FILED 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10th 1930

17

I HEREBY CERTIFY, That I attended deceased from June 14th, 1901, to Aug 10-, 1930, that I last saw h.. alive on Aug 9th, 1930, and that death occurred, on the date stated above, at 2.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

abt (duration) 2 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Chr. Depr. Psychosis

abt (duration) 29 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Frank J Flannery, M. D.

Aug 10th 1930 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Aug-11/1930
UNDERTAKER	ADDRESS
Stewart & Company	108 W Mt

...—2-29-28—L. F. S.—500 Bks.

McGeive

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59669 E 59669

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 1035 Ridgely ST. 21-31 WARD)

2—FULL NAME Michael J McGeive

(a) RESIDENCE NO. 1035 Ridgely ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary McGeive

ATE OF BIRTH (month, day, and year) Dec 15 1875

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	7	23	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Canning Factory

(c) Name of employer Canning Factory Co

RTHPLACE (city or town) State or country) Baltimore

0 NAME OF FATHER Michael J McGeive

1 BIRTHPLACE OF FATHER (city or town) City
(State or country)

2 MAIDEN NAME OF MOTHER Mary McGeive

3 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

Informant Mrs Mary McGeive

(Address) 1035 Ridgely St

Filed AUG 11 1930 H. A. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7th 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 12, 1928, to Aug 7, 1930

that I last saw him alive on Aug 6, 1930

and that death occurred, on the date stated above, at 6 0 m. EST

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

& Intestines

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Toxic Aberration

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Koos, M. D.

8/8, 1930 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	8/11/1930
20 UNDERTAKER	ADDRESS
E. J. Fanning Son	1938 E. Lafayette Ave

ec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59670 | CERTIFICATE OF DEATH. | 38 E 59670

REGISTERED NO.

1-PLACE OF DEATH Balto. City Hosp.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... ST. ... WARD) 57-2

2-FULL NAME William Sampson

(a) RESIDENCE NO. 564 Dolphin St. ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of -

DATE OF BIRTH (month, day, and year) 1890

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Wm. Sampson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Records of
(Address) Balto. City Hospitals

Filed 8-11 1930, HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-3-30

17 I HEREBY CERTIFY, That I attended deceased from 1-4-30, 19..., to 8-8-30, 19..., that I last saw him alive on 8-8-30, 19..., and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta with aneurysm

Morethan (duration) yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Rupture of aneurysm (duration) yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? 1. Home 2. Hospital

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Podos. M. D.

8-8, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Aug 11 30

20 UNDERTAKER John H. Frazier

ADDRESS 1027 Druid Hill Ave

Spec.—1-10-21—M&T—1500 Blks.

59671 HEALTH DEPARTMENT—CITY OF BALTIMORE E 59671

CERTIFICATE OF DEATH. 161-00

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 917 Leadenhall ST. 23-31 WARD)

2-FULL NAME Baby Girl Graves

(a) RESIDENCE NO. 917 Leadenhall ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1/8 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 8, 1930

7 AGE — Years — Months — Days — If LESS than 1 day 2½ hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Dalton Rodgers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk, Va

12 MAIDEN NAME OF MOTHER Gladys Graves

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk, Virginia

14 Informant Gladys S. Graves
(Address) 917 Leadenhall

15 Filed 1-1 1930 C. H. Kelly BAY JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8 1930 to Aug 8 (3:00 A.M. Aug 8) 1930, that I last saw her alive on 3:00 A.M. Aug 8 1930, and that death occurred, on the date stated above, at 4:50 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1/8 ds.

CONTRIBUTORY (Secondary) Prolonged Labor

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

8/9 1930 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary — DATE OF BURIAL Aug 9 1930

UNDERTAKER Jas A Hayes — ADDRESS 142 Arlington Ave

c.—1-30—M. & T.—250 1930

HEALTH DEPARTMENT—CITY OF BALTIMORE

59672

CERTIFICATE OF DEATH.

90 E 59672

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 1117 N. Monroe ST. 16-22 WARD)

2-FULL NAME Harry Summerfield King

(a) RESIDENCE NO. 1117 N. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie King.

DATE OF BIRTH (month, day, and year) Mar. 16 1861

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	4	24	

OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 8 yrs. 013

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Prince Geo. Co. Md.

10 NAME OF FATHER Henry King.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Amanda Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Mrs Sophie King

(Address) 1117 N Monroe St

Filed ... 19 ... H. [illegible] JONES, M. D. Registrar

AUG 11 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Aug 8, 1930

that I last saw him alive on Aug 7, 1930

and that death occurred, on the date stated above, at Eas. Stand. Time 11.25 P.M.

The CAUSE OF DEATH* was as follows: Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebro-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam

(Signed) Bartus J. Bagg M.D.

, 19 (Address) 2229 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Aug 11 1930

20 UNDERTAKER Wm J. Pickner & Sons ADDRESS North Ave

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 13th DAY July

OF 1965 THE MICROPHOTOGRAPHS APPEARING

HEREIN STARTING WITH #E 56476 Apr. 24, 1930 AND

ENDING WITH #E 59672- Aug. 11, 1930 ARE AC-

CURATE AND COMPLETE REPRODUCTIONS OF THE

RECORDS OF THE DEPARTMENT OF Health

BUREAU OF Vital Statistics AS DELIVERED

IN THE REGULAR COURSE OF BUSINESS FOR

PHOTOGRAPHING, AND THAT:

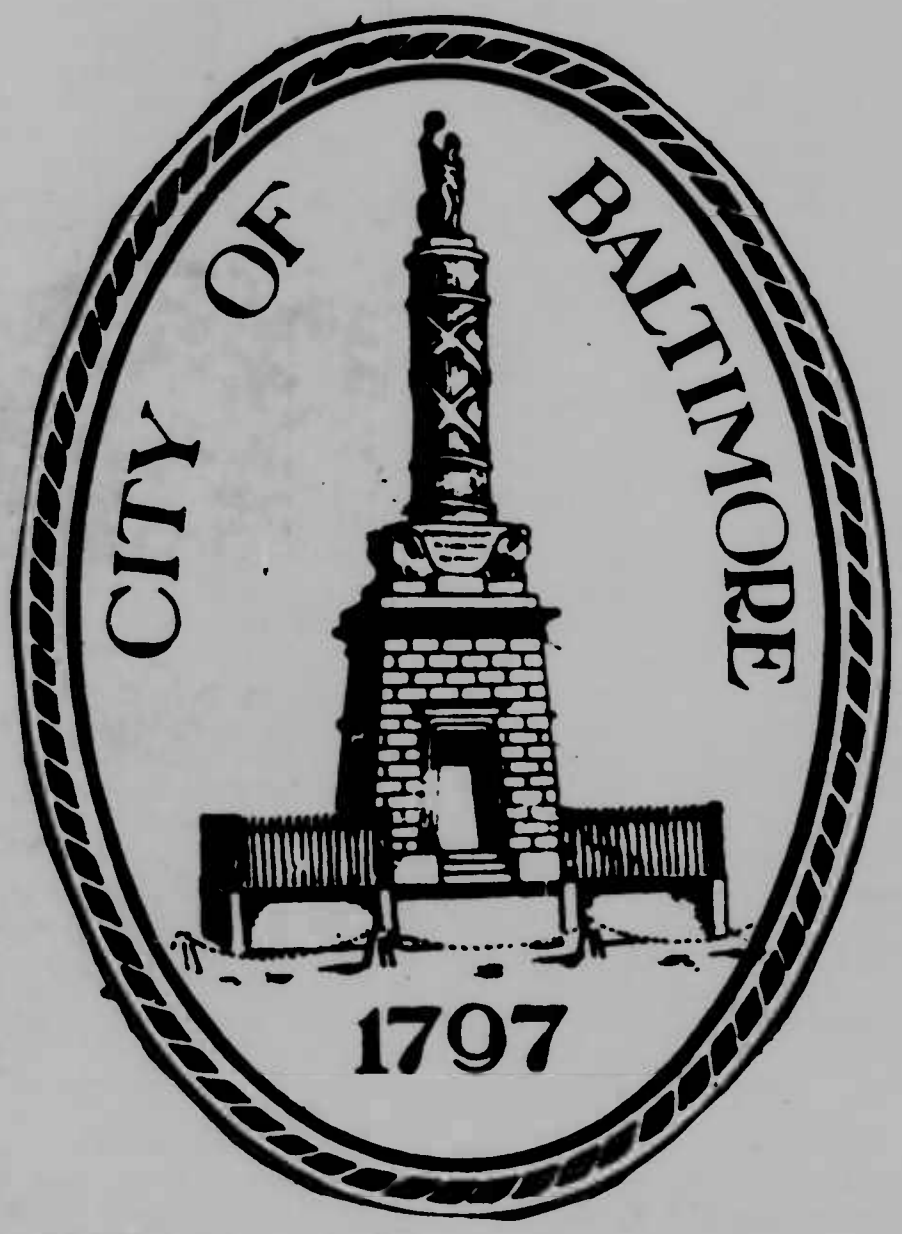
TO THE BEST OF MY KNOWLEDGE THE MICROFILM

MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU

OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC

COPY.

CAMERA OPERATOR: D. MacFaul



END OF REEL